Patricia M. French
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July 2, 2005

BY OVERNIGHT DELIVERY AND E-FILE

Mary L. Cottrell, Secretary
Department of Telecommunications and Energy
One South Station
Boston, MA 02110

Re: Bay State Gas Company, D.T.E. 05-27

Dear Ms. Cottrell:

Enclosed for filing, on behalf of Bay State Gas Company ("Bay State"), please find Bay State's responses to the following information requests:

From the Attorney General:

AG-1-50 (BULK) AG-2-10 (Supp) AG-3-30 (BULK) AG-9-19

AG-12-3 AG-12-4 AG-12-16 (BULK) AG-14-19 (CD)

AG-22-51 AG-25-6 (BULK)

From the Department:

DTE-1-2 DTE-5-16 (BULK) DTE-5-27 DTE-11-29 DTE-11-30

DTE-11-31 DTE-11-32 DTE-14-1 DTE-16-19 (Supp) DTE-16-21 (BULK)

DTE-18-18 (Revised) DTE-18-23 (Revised) DTE-21-8

DTE-23-1 DTE-23-2 DTE-23-3 DTE-23-4 DTE-23-5

DTE-23-6 DTE-23-7 DTE-23-8

From MOC:

MOC-1-5 MOC-1-8

From the UWUA Local 273:

UWUA-1-6 UWUA-1-16 UWUA-1-25 (BULK) UWUA-2-18 (BULK)

UWUA-2-19 UWUA-3-38 UWUA-3-40

From the USWA:

USWA-1-1 USWA-1-2 USWA-1-3 USWA-1-4 USWA-1-5

USWA-1-6 USWA-1-7 USWA-1-8 USWA-3-1 USWA-3-2

USWA-3-3 USWA-3-4 USWA-3-5 USWA-3-6 USWA-3-7

USWA-3-8 USWA-3-9 USWA-3-10

Please do not hesitate to telephone me with any questions whatsoever.

Very truly yours,

Patricia M. French

cc: Per Ground Rules Memorandum issued June 13, 2005:

Paul E. Osborne, Assistant Director – Rates and Rev. Requirements Div. (1 copy)
A. John Sullivan, Rates and Rev. Requirements Div. (4 copies)
Andreas Thanos, Assistant Director, Gas Division (1 copy)
Alexander Cochis, Assistant Attorney General (4 copies)
Service List (1 electronic copy)

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF TELECOMMUNICATIONS AND ENERGY

RESPONSE OF BAY STATE GAS COMPANY TO THE
FIRST SET OF INFORMATION REQUESTS FROM THE ATTORNEY GENERAL
D. T. E. 05-27

Date: July 1, 2005

Responsible: Steven A. Barkauskas, Vice President Total Rewards

AG-1-50: Please provide a breakdown of the year-end 2003 and 2004 expenses, for all non-pension benefits available to employees. For each benefit, include a detailed description of the benefit and the conditions that each employee must meet to be entitled to the benefit.

RESPONSE: See Attachment AG-01-50 (a) pages 1 – 4 for a breakdown of the year-end 2003 and 2004 expenses, for all non-pension benefits available to employees. The Company notes that Page 3 of Att. AG-01-50 matches Pages 11-12 of Exh. BSG/JES-1 Workpaper JES-6, and Page 4 of Att. AG-01-50 matches Page 13 of Exh. BSG/JES-1 Workpaper JES-6.

See the following list of attachments for detailed Summary Plan Descriptions ("SPD") of the benefits offered to Bay State's employees and NiSource employees who support the Company, including the conditions that each employee must meet to be entitled to the benefit.

Attachment AG-01-50 (b) – BSG Brockton Clerical Employees SPD

Attachment AG-01-50 (c) – BSG Brockton Union Employees SPD

Attachment AG-01-50 (d) – BSG Lawrence Union Employees SPD

Attachment AG-01-50 (e) – BSG Northampton Union Employees SPD

Attachment AG-01-50 (f) – BSG Operating Employees SPD

Attachment AG-01-50 (g) – BSG Salaried Employees AB SPD

Attachment AG-01-50 (h) – BSG Salaried Employees FAP SPD

Attachment AG-01-50 (i) – BSG Springfield Clerical / Technical Employees FAP SPD

Attachment AG-01-50 (j) – BSG Springfield Employees FAP SPD

Attachment AG-01-50 (k) – BSG Salaried Savings Plan SPD

Attachment AG-01-50 (l) – BSG Union Savings Plan SPD

Attachment AG-01-50 (m) – NiSource Employees Dental Plan SPD

Attachment AG-01-50 (n) – NiSource Employees Final LTD SPD

Attachment AG-01-50 (o) – NiSource Employees FSA SPD

Attachment AG-01-50 (p) – NiSource Employees Medical SPD

Attachment AG-01-50 (q) – NiSource Employees Overview SPD

Attachment AG-01-50 (r) – NiSource Employees Travel Accident SPD

Attachment AG-01-50 (s) – NiSource Employees Vision SPD

Attachment AG-01-50 (t) – NiSource Employees ST Disability SPD

BULK ATTACHMENT

Bay State Gas Company
Adjustmentments to Operating Expenses
Test Year Ended December 31, 2003
Health Insurance Based on 2003 Rates

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
				[2]*[3]			[5]*[6]	[2]+[5]	[4]+[7]
		Non-Union Group			**Union Group**				
line	**Type of Plan**	**# of People**	**Net Annual Rate**	**Cost**	**# of People**	**Net Annual Rate**	**Cost**	**Total # of People**	**Total Cost**
1									
2	BCBS Master Medical (IND)								
3	EE		$5,410	$0	6.0	$5,410	$32,500	6.0	$32,500
4	EE+1		$10,826	$0	14.0	$10,826	$151,600	14.0	$151,600
5	Family		$14,608	$0	10.0	$14,608	$146,100	10.0	$146,100
6									
7	Havard Pilgram HMO								
8	EE		$3,399	$0	7.0	$3,399	$23,800	7.0	$23,800
9	EE+1		$6,797	$0	22.0	$6,797	$149,500	22.0	$149,500
10	Family		$9,176	$0	57.0	$9,176	$523,000	57.0	$523,000
11									
12	HMO Blue (BCBS-MA)								
13	EE		$3,756	$0	3.0	$3,756	$11,300	3.0	$11,300
14	EE+1		$7,512	$0	1.0	$7,512	$7,500	1.0	$7,500
15	Family		$845	$0	10.0	$845	$8,500	10.0	$8,500
16									
17	UHC POS								
18	EE		$5,080	$0	-	$5,080	$0	-	$0
19	EE+1	-	$10,160	$0	-	$10,160	$0	-	$0
20	Family	-	$13,716	$0	1.0	$13,716	$13,700	1.0	$13,700
21									
22	United OOA								
23	EE		$7,102	$0	-	$7,102	$0	-	$0
24	EE+1		$14,204	$0	-	$14,204	$0	-	$0
25	Family		$19,175	$0		$19,175	$0	-	$0
26									
27	Tufts HMO (Union)								
28	EE	9.9	$3,221	$31,900	33.3	$5,896	$196,300	43.2	$228,200
29	EE+Spouse	15.0	$6,441	$96,600	29.3	$11,792	$345,500	44.3	$442,100
30	Family	36.7	$8,696	$319,100	40.9	$18,277	$747,500	77.6	$1,066,600
31									
32	Anthem BCBS NH/ME HMO (Union)								
33	EE	-	$3,661	$0	1.0	$3,661	$3,700	1.0	$3,700
34	EE+Spouse		$7,322	$0	2.0	$7,322	$14,600	2.0	$14,600
35	Family	-	$9,885	$0	1.0	$9,885	$9,900	1.0	$9,900

Bay State Gas Company
Adjustmentments to Operating Expenses
Test Year Ended December 31, 2003
Health Insurance Based on 2003 Rates

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
				[2]*[3]			[5]*[6]	[2]+[5]	[4]+[7]
		Non-Union Group			**Union Group**				
			Net			**Net**			
		# of	**Annual**		**# of**	**Annual**		**Total # of**	
line	**Type of Plan**	**People**	**Rate**	**Cost**	**People**	**Rate**	**Cost**	**People**	**Total Cost**
36									
37	Health New England HMO								
38	EE		$3,208	$0	15.0	$3,208	$48,100	15.0	$48,100
39	EE+Spouse	-	$6,417	$0	23.0	$6,417	$147,600	23.0	$147,600
40	Family	-	$8,663	$0	45.0	$8,663	$389,800	45.0	$389,800
41									
42	BCBS Blue Choice (POS)								
43	EE		$3,082	$0	6.7	$3,082	$20,700	6.7	$20,700
44	EE+Spouse		$6,164	$0	11.2	$6,164	$69,000	11.2	$69,000
45	Family		$8,322	$0	18.2	$8,322	$151,500	18.2	$151,500
46									
47	PPO								
48	EE	-	$3,492	$0	-	$3,492	$0	-	$0
49	EE+Spouse	-	$6,984	$0	-	$6,984	$0	-	$0
50	Family	-	$10,825	$0	-	$10,825	$0	-	$0
51									
52	Standard Plan 1								
53	EE	-	$3,398	$0	1.0	$3,398	$3,400	1.0	$3,400
54	EE+Spouse	-	$6,797	$0		$6,797	$0	-	$0
55	Family	-	$10,535	$0		$10,535	$0	-	$0
56									
57	Standard Plan 2								
58	EE	1.0	$3,177	$3,200	1.0	$3,177	$3,200	2.0	$6,400
59	EE+Spouse	-	$6,354	$0		$6,354	$0	-	$0
60	Family	3.7	$9,849	$36,400		$9,849	$0	3.7	$36,400
61									
62	Totals	66.3		$487,000	359.6		$3,218,000	425.9	$3,706,000
63									
64	Enrollment based on 2003 enrollment								
65	Rates based on 2003 rates								
66	Lines 1-45 are fully insured plans, lines 47-66 are self insured plans								

Bay State Gas Company
Adjustmentments to Operating Expenses
Test Year Ended December 31, 2004
Health Insurance Based on Current Rates (2004)

line	[1] Type of Plan	[2] Non-Union Group # of People	[3] Non-Union Group Net Annual Rate	[4] [2]*[3] Non-Union Group Cost	[5] Union Group # of People	[6] Union Group Net Annual Rate	[7] [5]*[6] Union Group Cost	[8] [2]+[5] Total # of People	[9] [4]+[7] Total Cost
1									
2	BCBS Master Medical (IND)								
3	EE		$6,127	$0	10.0	$6,127	$61,300	10.0	$61,300
4	EE+Spouse		$13,347	$0	17.0	$13,347	$226,900	17.0	$226,900
5	EE+Child(ren)		$13,347	$0	1.0	$13,347	$13,300	1.0	$13,300
6	Family		$16,543	$0	10.0	$16,543	$165,400	10.0	$165,400
7									
8	Havard Pilgram HMO								
9	EE		$3,955	$0	13.5	$3,955	$53,400	13.5	$53,400
10	EE+Spouse		$7,910	$0	32.9	$7,910	$260,200	32.9	$260,200
11	EE+Child(ren)		$7,910	$0	3.8	$7,910	$30,100	3.8	$30,100
12	Family		$10,678	$0	57.5	$10,678	$614,000	57.5	$614,000
13									
14	HMO Blue (BCBS-MA)								
15	EE		$4,161	$0	5.5	$4,161	$22,900	5.5	$22,900
16	EE+Spouse		$8,323	$0	2.0	$8,323	$16,600	2.0	$16,600
17	EE+Child(ren)		$8,323	$0	2.7	$8,323	$22,500	2.7	$22,500
18	Family		$11,236	$0	9.0	$11,236	$101,100	9.0	$101,100
19									
20	UHC POS								
21	EE	1.0	$5,842	$5,800	1.0	$5,842	$5,800	2.0	$11,600
22	EE+Spouse	-	$11,684	$0	2.0	$11,684	$23,400	2.0	$23,400
23	EE+Child(ren)	-	$11,684	$0	-	$11,684	$0	-	$0
24	Family	-	$15,773	$0	-	$15,773	$0	-	$0
25									
26	United OOA								
27	EE		$8,167	$0	-	$8,167	$0	-	$0
28	EE+Spouse		$16,334	$0	-	$16,334	$0	-	$0
29	EE+Child(ren)		$16,334	$0	-	$16,334	$0	-	$0
30	Family		$22,051	$0	1.0	$22,051	$22,100	1.0	$22,100
31									
32	Tufts HMO (Union)								
33	EE	13.0	$4,192	$54,500	24.4	$4,192	$102,300	37.4	$156,800
34	EE+Spouse	20.0	$8,345	$166,900	14.4	$8,345	$120,200	34.4	$287,100
35	EE+Child(ren)	1.7	$8,345	$14,200	9.7	$8,345	$80,900	11.4	$95,100

36	Family	34.1	$11,252	$383,700	28.7	$11,252	$322,900	62.8	$706,600
37									
38	Anthem BCBS NH/ME HMO (Union)								
39	EE	-	$3,959	$0	-	$3,959	$0	-	$0
40	EE+Spouse	1.0	$7,880	$7,900	2.0	$7,880	$15,800	3.0	$23,700
41	EE+Child(ren)	-	$7,880	$0	-	$7,880	$0	-	$0
42	Family	-	$10,625	$0	1.0	$10,625	$10,600	1.0	$10,600
43									
44	Health New England HMO								
45	EE	1.0	$3,312	$3,300	16.0	$3,312	$53,000	17.0	$56,300
46	EE+Spouse	-	$6,624	$0	23.0	$6,624	$152,400	23.0	$152,400
47	EE+Child(ren)	-	$6,624	$0	5.0	$6,624	$33,100	5.0	$33,100
48	Family	-	$10,268	$0	43.0	$10,268	$441,500	43.0	$441,500
49									
50	BCBS Blue Choice (POS)*								
51	EE		$3,415	$0	8.4	$3,415	$28,700	8.4	$28,700
52	EE+Spouse		$6,830	$0	12.5	$6,830	$85,400	12.5	$85,400
53	EE+Child(ren)		$6,830	$0	4.7	$6,830	$32,100	4.7	$32,100
54	Family		$9,221	$0	20.9	$9,221	$192,700	20.9	$192,700
55	*Plan will not be offered in 2005. Rates are shown at 2004 rates trended at 14%.								
56	PPO								
57	EE	3.0	$3,113	$9,300	0.8	$3,113	$2,500	3.8	$11,800
58	EE+Spouse	3.0	$6,226	$18,700	-	$6,226	$0	3.0	$18,700
59	EE+Child(ren)	-	$5,915	$0	-	$5,915	$0	-	$0
60	Family	3.8	$9,650	$36,700	-	$9,650	$0	3.8	$36,700
61									
62	Standard Plan 1								
63	EE	0.8	$3,024	$2,400		$3,024	$0	0.8	$2,400
64	EE+Spouse	-	$6,048	$0		$6,048	$0	-	$0
65	EE+Child(ren)	-	$5,745	$0		$5,745	$0	-	$0
66	Family	-	$9,374	$0		$9,374	$0	-	$0
67									
68	Standard Plan 2								
69	EE	1.0	$2,815	$2,800		$2,815	$0	1.0	$2,800
70	EE+Spouse	-	$5,629	$0		$5,629	$0	-	$0
71	EE+Child(ren)	1.0	$5,348	$5,300		$5,348	$0	1.0	$5,300
72	Family	-	$8,726	$0		$8,726	$0	-	$0
73									
74	Totals	84.4		$712,000	383.4		$3,313,000	467.8	$4,025,000
75									
76	Enrollment based on 2004 enrollment with fractional employees								
77	Rates based on 2004 rates								
78	Lines 1-55 are fully insured plans, lines 56-72 are self insured plans								

Bay State Gas Company
Adjustmentments to Operating Expenses
Test Year Ended December 31, 2003
Dental Insurance Based on 2003 Rates

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]
				[2]*[3]			[5]*[6]	[2]+[5]	[4]+[7]
		Non-Union Group			**Union Group**				
line	**Type of Plan**	**# of People**	**Net Annual Rate**	**Cost**	**# of People**	**Net Annual Rate**	**Cost**	**Total # of People**	**Total Cost**
1									
2	BCBS Dental								
3	EE	-	$308	$0	62.3	$308	$19,200	62.3	$19,200
4	EE+Spouse	-	$614	$0	100.6	$614	$61,800	100.6	$61,800
5	Family	-	$922	$0	188.6	$922	$174,000	188.6	$174,000
6									
7	Basic Dental								
8	EE	9.0	$235	$2,100	10.2	$235	$2,400	19.2	$4,500
9	EE+Spouse	14.1	$533	$7,500	11.1	$533	$5,900	25.2	$13,400
10	Family	37.6	$809	$30,400	7.5	$809	$6,100	45.1	$36,500
11									
12	Dental Plus								
13	EE	-	$250	$0	2.8	$250	$700	2.8	$700
14	EE+Spouse	2.7	$539	$1,500	2.0	$539	$1,100	4.7	$2,600
15	Family	9.5	$817	$7,800	1.7	$817	$1,400	11.2	$9,200
16									
17	Totals	72.9		$49,000	386.8		$273,000	459.7	$322,000
18									
19	Enrollment based on 2003 enrollment								
20	Rates based on 2003 renewal rates								
21	Lines 1-6 are fully insured plans, lines 7-18 are self insured plans								

Bay State Gas Company
Adjustmentments to Operating Expenses
Test Year Ended December 31, 2004
Health Insurance Based on Current Rates (2004)

	[1]	[2]	[3]	[4] [2]*[3]	[5]	[6]	[7] [5]*[6]	[8] [2]+[5]	[9] [4]+[7]
		Non-Union Group			**Union Group**				
line	**Type of Plan**	**# of People**	**Net Annual Rate**	**Cost**	**# of People**	**Net Annual Rate**	**Cost**	**Total # of People**	**Total Cost**
1									
2	BCBS Dental								
3	EE	1.0	$320	$300	76.8	$320	$24,600	77.8	$24,900
4	EE+Spouse	-	$639	$0	114.8	$639	$73,300	114.8	$73,300
5	EE+Child(ren)	-	$639	$0	29.6	$639	$18,900	29.6	$18,900
6	Family	-	$959	$0	185.6	$959	$178,000	185.6	$178,000
7									
8	Basic Dental								
9	EE	8.5	$336	$2,900	0.8	$336	$300	9.3	$3,200
10	EE+Spouse	10.4	$672	$7,000	-	$672	$0	10.4	$7,000
11	EE+Child(ren)	0.8	$639	$500	-	$639	$0	0.8	$500
12	Family	16.0	$1,042	$16,700	-	$1,042	$0	16.0	$16,700
13									
14	Dental Plus								
15	EE	7.4	$332	$2,500	-	$332	$0	7.4	$2,500
16	EE+Spouse	17.4	$663	$11,500	0.8	$663	$500	18.2	$12,000
17	EE+Child(ren)	1.8	$630	$1,100	-	$630	$0	1.8	$1,100
18	Family	28.2	$1,028	$29,000	0.8	$1,028	$800	29.0	$29,800
19									
20	Totals	91.5		$72,000	409.2		$296,000	500.7	$368,000
21									
22	Enrollment based on 2004 enrollment with fractional employees								
23	Rates based on 2004 renewal rates								
24	Lines 1-6 are fully insured plans, lines 7-18 are self insured plans								

Bay State Gas Company Pension Plan

Brockton Clerical/Technical Division

Utility Workers' Union of America, AFL-CIO-CLC, Local Union # 273, Clerical/Technical Unit

Plan # 008

Agreement Period:
03/31/03 - 04/01/09

Summary Plan Description (SPD)

HA Comments:
5/22/05

Contents

As a union employee covered by a collective bargaining agreement between Bay State Gas Company (the "Company") and the Utility Workers' Union of America, AFL-CIO-CLC Local #273, Clerical/Technical Unit you were enrolled in the Bay State Gas Company Pension Plan ("Plan") if you satisfy the criteria described in the Eligibility and Enrollment section.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of January 1, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion, subject to the terms of the applicable collective bargaining agreements.

Introduction to the Plan

As a participant, you do not make any contributions to the Plan. The Plan is designed to provide you with a monthly income at retirement, based on your years of Credited Service and your final average pay. The Plan also provides a monthly benefit payable to your eligible spouse in the event of your death.

Under the Plan, your benefits are based on certain factors at the time you retire:

- Your years of Credited Service. Your years of Credited Service are based on your total period of participation in the Plan.

- Your final average pay. Your final average pay is the average of your Base Pay during the highest consecutive 36 months in your last 120 months of employment (subject to a Plan wage cap); and

- Your age at the time you retire.

Benefit Options

The following pension benefit options are available under the Plan:

- A normal retirement pension if you retire on or after your normal retirement age (age 65).

- An early retirement pension if you retire on or after age 55 and before reaching age 65 with at least 10 years of Credited Service.

- A deferred vested benefit based on your final average pay and Credited Service up to your termination date if you leave employment with at least five years of Credited Service, but before you are eligible for a normal or early retirement pension. Your years of Credited Service for this purpose are based on your period of employment with the Company and its affiliates.

Your pension benefit is payable for your lifetime. In addition, your eligible spouse~~, or other beneficiary you designate (with your spouse's consent, if applicable),~~ may receive a continuing benefit in the event of your death.

Highlights of the Plan

Employee Contribution	None
Company Contribution	Yes; 100%
Vesting	100% vested after 5 years of Credited Service
Base Pay	Straight time wages (exclusive of all daily and weekly overtime, bonuses, supplementary incentive compensation payments, retirement benefits and other forms of non-recurring compensation) up to a wage cap of $45,000
When Your Benefit is Paid *(provided you are vested)*	• When you terminate employment • When you reach early or normal retirement age • In the event of your death • April 1 of the year after the year in which your reach age 70-1/2
Retirement Age	• Normal Retirement (later of age 65 or 5th anniversary of participant) • Early Retirement (age 55 with 10 years of Credited Service)
Payment Options	• Various Monthly Annuity Options • Lump Sum
Survivor Benefit	• Monthly Annuity Option

Eligibility and Enrollment

Generally, you are eligible to participate in the Plan if you are an employee of Bay State Gas Company – Brockton Clerical/Technical Division and you are covered by a collective bargaining agreement between the Company and the Utility Workers of America AFL-CIO-CLC on behalf of Local Union No. 273, Clerical/Technical Unit covering the period from March 31, 2003 to April 1, 2009.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts when your employment begins. You are automatically enrolled in the Plan.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your collective bargaining agreement no longer provides for participation in the Plan;
- The Plan ends; or
- You die.

Credited Service

Credited Service is used in determining your eligibility for a pension benefit, as well as in calculating the amount of your benefit. A year of Credited Service for this purpose means each ~~Plan~~ calendar y~~Y~~ear during which you complete at least 1,000 hours of work as a Plan participant. Credited Service used to calculate your pension benefit may not exceed 45 years.

If you work and are paid for less than 1,000 hours in any year, you will not be credited with a year of Credited Service for that year. If you return to the Company as an eligible employee, working at least 1,000 hours a year, you will again be eligible to earn a year of Credited Service under the Plan.

Vesting Service

The vesting of (your nonforfeitable right to) your pension is based on your years of Credited Service. For purposes of vesting only, Credited Service will also include your service with the Company or any affiliate during which you were not eligible to participate in the Plan. You are 100% vested in your pension benefit after completing five years of Credited Service with the Company and/or an affiliate.

Your vesting Service is measured from the date you join the Company or any affiliate to the date you terminate, die or retire. Special rules may apply if you experience a break in service, become disabled or if you were previously a leased employee of the Company or an affiliate.

Base Pay

Base Pay is your straight time wages (exclusive of all daily and weekly overtime, bonuses, supplementary incentive compensation payments, retirement benefits and other forms of non-recurring compensation). ~~up to an annual wage cap of $45,000.~~

Final Average Pay

Final average pay is calculated as the average Base Pay during the 36 consecutive months with the Company that gives you the highest average earnings out of the last ten years. The maximum final average pay is $45,000.

Break in Service

You have a Break in Service if you do not complete more than 500 hours of service in a Plan Year. The length of broken Credited Service is used to determine whether to reinstate Credited Service earned before termination if you are later re-employed.

If you were not vested when you had a Break in Service, you keep all your Credited Service if the Break ends before the period of broken service equals five years, or if you return to work before the period of broken service is greater than the Credited Service you earned before your termination ~~(if less than five years)~~. If the length of your Break in Service is more than the greater of your period of prior Credited Service or five ~~consecutive one-year Breaks in Service~~years and you were not vested, you lose credit for all your prior Credited Service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when your Break in Service began, the Credited Service you earned before the Break will be added to the Credited Service you earn when the Break ends. However, the Company does not count the interim period you were away as part of your Credited Service.

Break in Service and Leaves

Note that any year in which you receive credit for 500 or more hours is not considered a break in service. When determining if a Break in Service has occurred, up to 501 hours will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be more beneficial to you in preventing a Break in Service.

You will not have a Break in Service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn Credited Service ~~for eligibility and vesting and determining the amount of your benefit~~ during your disability. Credited Service shall cease to be credited as of the earliest of the date on which your disability ends; the date on which you return to employment, or the date your benefits under the Plan commence.

Transfers

From Affiliate

If you transfer from employment providing coverage under an affiliate's defined benefit plan on or after July 1, 2002 to union employment providing coverage under the Plan, you will participate in the Plan, subject to the eligibility and enrollment provisions of the Plan.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's defined benefit plan, your accrued benefit under the Plan will be frozen as of the date of your transfer.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

When Your Pension Benefit is Paid

~~When your pension benefit is paid, y~~You are entitled to your accrued benefit as soon as possible after:

- You retire at or after the later of age 65, or your fifth anniversary of Plan participation, or at or after age 55 with 10 years of Credited Service;
- You leave the Company before retirement with at least 5 years of service; or
- When you die.

You can receive the value of your vested pension benefit when you retire. Normal retirement is the later of age 65 or your fifth anniversary of Plan participation. If you meet the five year Credited Service requirement, you could ~~retire as early as age 60 and~~ receive a reduced benefit immediately, or you could elect to defer payment.

Under the Plan, your vested pension benefit is payable to you upon retirement. You are vested in your benefit after you complete five years of Credited Service. Credited Service is measured for this purpose from your first day of work at the Company or an affiliate to the date your employment ends. Special rules may apply if you leave the Company and later return, if you are a leased employee, if you are on LTD or on military leave. For more information regarding these special rules, see the Plan Administrator.

Designation of Beneficiary

If you are married and if you die before commencing your pension benefit, a death benefit will be paid to your surviving spouse, if any. If you die after commencing your pension benefit, your spouse, if you are married at the time your benefit commences, is your beneficiary, unless with your spouse's consent, you have elected an optional form of payment with a different beneficiary.

If you are single and you die before commencing your pension benefit, there is no death benefit. If you die after commencing your pension benefit, your beneficiary may receive a pension benefit ~~if you have selected an~~depending on the optional form of payment that you elect.

Applying for Benefits

If you are eligible to begin receiving benefits, you can call the Bay State Gas Pension Source at **1-877-587-5866** ~~MySource for Human Resources at **1-888-640-3320** or visit the Web site (**www.mysourceforhr.com**)~~ to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your benefits begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible upon your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Upon retirement you can decide to:

- Receive your full accrued benefit if you retire at normal retirement age.
- Receive a reduced accrued benefit, if you retire early, based on your age and Credited Service at the time you retire.
- Defer your benefit to a later date, if you retire early. Your benefit is calculated as of the date you actually retire with any reduction based on the date you later elect to begin receiving benefits. If you wait until your normal retirement date, the reduction does not apply.

Normal Retirement

When you retire at age 65 or later, your monthly pension benefit will be based on your Credited Service (up to a maximum of 45 years) and your final average pay (up to a Plan wage cap of $45,000). Your monthly pension benefit will be equal to the greatest of:

1. 1.25% of your final average pay, subject to a wage cap of $45,000, multiplied by your years of Credited Service not in excess of 45 years;
2. The annual pension benefit to which you would have been entitled under the terms of the Plan prior to January 1, 1989, or if you were covered under any predecessor to the Plan, the amount of your accrued benefit under the predecessor plan as of the date that plan merged with this Plan, but based only on your Credited Service accrued through April 1, 1995; and
3. Your accrued benefit as of March 31, 1998 based on the schedule of benefits set forth below, but with total Credited Service accrued as of March 31, 1988.

Operating Wage Grade	Retirement on or after 4/1/97
1 through 4	$19.00
5 through 7	$24.00

8 and above	$30.00

Example 1: Normal Retirement Benefit, if Single

Bob has worked for the Company for 35 years with an annual ~~monthly~~ final average pay of $~~3,750~~45,000. He retires at age 65. His pension benefit is calculated as follows:

1.25% x $~~3,750~~45,000.00 x 35 = $~~1,640.63~~19,687.50 per ~~month~~ year

$~~1,640.63~~19,678.50 /~~x~~ 12 = $~~19,687.50~~1,640.63 ~~annual pension benefit~~per month

(Minus any benefit to which Bob may be entitled under any Predecessor Plan)

This is the pension amount payable to Bob if he is single. If he is married, the benefit will be paid under a 50% Joint and Survivor Annuity as shown in Example 2.

Example 2: Normal Retirement Benefit, if Married

If you are married and have not chosen (with a notarized, written spousal consent) another method of receiving your pension, your surviving spouse will automatically receive, after your death, a benefit equal to one-half of your pension benefit as a 50% Joint and Survivor Annuity. Your spouse will receive this benefit for the rest of his or her life. Because this arrangement will usually result in benefit payments being paid over a longer period of time than under the single life annuity, the amount of your benefit is reduced by a factor which takes into account your spouse's age and your age at the time of your retirement.

Using the example above, if Bob is married, he and his spouse are age 65, and he has ~~not waived~~elected the 50% Joint and Survivor Annuity, his benefit would be calculated as follows:

Single life annuity *(as previously calculated in Example 1)*	$1,640.63
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.875
Total Monthly Benefit payable during Bob's lifetime	$1,435.55
Total Monthly Benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$717.78

If Bob and his wife elected another form of payment, as described in the "Forms of Payment" section, the monthly benefit amount would change.

Early Retirement

You may retire as early as the first of the month following or coinciding with the date you reach age 55, if you have completed at least 10 years of Credited Service (early retirement). You may

choose to start receiving your pension benefit in any month on or after your early retirement or elect to start receiving your pension benefit at age 65, based upon your final average pay and Credited Service at the time of early retirement.

Your early retirement benefit is based on the same formula used for normal retirement, reduced by a factor that varies by your age and years of Credited Service:

- ~~[~~If you have completed at least 10, but less than 25, years of Credited Service and retire after age 55 but prior to 65, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and your normal retirement date.~~]~~

- If you have completed at least 25 years of Credited Service and retire after reaching age 55 but prior to 60, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and age 62.

- If you have completed at least 25 years of Credited Service and retire after reaching age 60, there is no reduction factor.

Example 3: Early Retirement with 25 years of Credited Service

Suppose Bob wants to retire at age 60 after 25 years of Credited Service and wants pension benefits to start as soon as he retires. Assume his final average pay is $~~3,750~~45,000:

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $~~3,750~~45,000.00 x 25 = $~~1,171.88~~14,062.50 per ~~month~~year

$14,062.50 / 12 = $1,171.88 per month

Reduction for Early Retirement

Because Bob has 25 years of Credited Service and is retiring at age 60, there is no reduction. Therefore, Bob's monthly pension benefit payable at age 60 is the same as would be payable at 65, or $1,171.88.

Example 4: Early Retirement with 24 Years of Credited Service

Suppose Bob, in the above example, had only 24 years of Credited Service at the time he elected to retire at age 60.

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $~~3,750~~45,000.00 x 24 = $~~1,125.00~~13,500.00 per ~~month~~year

$13,500.00 / 12 = $1,125.00 per month

Reduction for Early Retirement

Bob's normal retirement benefit is reduced 3/10 of 1% for each full month that he retires before he reaches age 65 (59 months in this case).

3/10 of 1% x 59 months = 17.7%

Thus an early retirement reduction factor of 82.3% (1 – 17.7%) will be applied to the Normal Retirement Benefit calculated above.

Bob's normal retirement benefit at age 65 less the reduction for early retirement equals the monthly single life annuity payable to Bob at early retirement.

$1,125.00 x ~~17.70~~82.3% = $~~199.13 reduction~~925.88 per month

~~$1,125.00 - $199.13 = $925.87 per month~~

The monthly pension annuity benefit payable to Bob at early retirement would be $925.~~87~~88.

If Bob is married and his spouse is age 58, his early retirement benefit would be paid as follows:

Single life annuity starting at age 60	$925.~~87~~88
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.865
Total monthly pension benefit payable during Bob's lifetime	$800.~~88~~89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.~~44~~45

Supplemental Benefit

The Plan provides eligible employees a supplemental benefit when they elect to take early retirement. This supplemental benefit, also referred to as the "Social Security Bridge" or "Early Retirement Supplement ~~Benefit~~," is intended to provide additional retirement income if you retire on or after age 60 but before age 62.

If you retire on or after age 60 but before age 62, your pension will be increased, but only until you reach age 62 or die, whichever occurs sooner, by an amount equal to 2% of your final average pay

(subject to Internal Revenue Code limits) multiplied by your years of Credited Service (but not more than 25 years). However, your ~~pension benefit~~temporary Supplement ~~will not be increased to an amount greater than~~may not exceed the Primary Social Security Benefit to which you would be entitled at age 62.

Supplemental Benefit with 24 Years of Credited Service

Lets assume Bob retires at age 60 with 24 years of Credited Service. His final average pay is $45,000~~3,750~~. Bob's supplemental benefit from age 60 to age 62 would be the lesser of the following:

(1) Supplemental Benefit at Early Retirement

2% x $~~3,750~~45,000.00 x 24 yrs	=	$~~1,525.00~~ 21,600.00 per year~~month~~
$21,600.00 / 12	=	$1,800.00 per month

(2) Maximum Applied to Supplement – Assume the Primary Social Security Benefit provides an annual benefit of $13,000.00 for Bob payable at age 62. *This is the maximum amount he can receive as an early retirement supplement between ages 60 and 62. $13,000 ÷ 12 = $1,083.33 monthly. The total monthly supplement that Bob would receive would be $1,083.33.*

Total Monthly Benefit Payable at Early Retirement with 24 years of Service

The monthly pension benefit (*reduced early retirement benefits plus the supplement*) paid to Bob as a single life annuity would be:

From Age 60 to 62		**From Age 62 and Over**	
Reduced Early Retirement Benefit	$925.~~87~~88	Reduced Early Retirement Benefit	$925.~~87~~88
Plus	+	*Plus*	+
Early Retirement Supplement	$1,083.33	Early Retirement Supplement	~~$0~~.00
Total Monthly Single Life Annuity Benefit	**$2,009.~~20~~21**	**Total Monthly Single Life Annuity Benefit**	**$925.~~87~~88**

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the ~~supplemental~~ Supplemental ~~benefit~~ Benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

If Bob is married, his spouse is age 58 and he has ~~not waived~~elected the 50% Joint and Survivor Annuity, his early retirement benefit would be paid as follows:

From Age 60 to 62		**From Age 62 and Over**	

~~Total~~ Monthly Single Life Annuity Starting at Age 60	$~~2,009.20~~925.88	~~Total~~ Monthly Single Life Annuity Starting at Age 60	$925.~~87~~88
Multiply by reduction factor for a 50% Joint and Survivor Annuity option as determined by actuarial calculations	.865	Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865
Monthly 50% Joint & Survivor Annuity at Age 60	$800.89	Monthly 50% Joint & Survivor Annuity at Age 60	$800.89
Plus	+	*Plus*	+
Early Retirement Supplement (Social Security Bridge Benefit)	$1,083.33	Early Retirement Supplement (Social Security Bridge Benefit)	$0.00
Total Monthly Annuity Benefit payable during Bob's lifetime	$1,~~737.96~~884.22	Total Monthly Annuity Benefit payable during Bob's lifetime	$800.~~88~~89
Total Monthly Annuity Benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.~~44~~45	Total Monthly Annuity Benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.~~44~~45

From ages 60 ~~—~~to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

Note that Bob's Early Retirement Supplement is paid as a temporary Single Life Annuity regardless of which annuity form of payment Bob elects. If Bob dies before age 62, the Supplement will immediately stop.

If Bob had elected to take his pension payment as a lump sum, however, then the Supplement would also be distributed as a lump sum.

~~Bob's early retirement supplement is paid as a single life annuity, and no further supplemental benefits will be payable after his death.~~

Deferred Vested Pension

You will be eligible for a deferred vested pension beginning at age 65 if you terminate employment with the Company for any reason before you are eligible for early retirement but after you have completed at least five years of Credited Service. ~~You may begin your deferred vested pension in a reduced amount as early as age 60.~~ You may start your pension benefit immediately, or you may wait until your normal retirement age. Note that if you elect to take your benefit prior to age 65, your benefit will be reduced by~~The reduction is equal to [~~5/9~~]~~ of 1% for each full calendar month~~, during~~

~~the period from and after the date the benefit is to commence up to your~~ that commencement precedes the normal retirement date.

Death Benefits

If you are married and vested in your pension benefit and are either actively employed by the Company at the time of your death, or you have terminated employment with the Company and die before you start receiving your pension benefit, your spouse will receive a monthly benefit for his or her lifetime equal to the amount he or she would have received if you had died while receiving your pension benefit as a 50% Joint and Survivor Annuity. The death benefit will begin on the first day of the month following:

1. The date of your death if you were eligible for normal retirement when you died;

2. The date of your death if you were eligible for early retirement when you died (or can be delayed by your spouse to a later date), or

3. the date you would have reached early retirement age if you were not eligible for early retirement when you died.

The calculation assumes you were terminated or retired immediately preceding your death and were receiving a 50% Joint and Survivor Annuity. If you are single, no survivor benefit is payable. The Early Retirement Supplement is not payable after your death.

If you die after you begin receiving benefit payments under the Plan, your beneficiary could be entitled to a portion of the benefit you were receiving, depending on the optional form of payment you originally elected.

Minimum and Maximum Benefits From the Plan

Minimum Benefits

The minimum benefit payable will be:

- The benefit to which an employee would have been entitled as in effect for Plan Years prior to January 1, 1989; or

- In the case of an employee who was covered under any Predecessor Plan, the amount of his accrued monthly pension under such Predecessor Plan as of the applicable effective date of the consolidation or merger of such Predecessor Plan.

Maximum Benefits

There are certain Internal Revenue Code limits that affect the benefits payable to highly-paid employees, as defined by the IRS. If you are affected, you will be notified.

Payment Options

When you start receiving benefits, in accordance with Plan procedures, you can take your accrued benefit as an annuity that pays you a monthly income or in a lump sum.

Payment Forms

You will normally receive your pension benefit in the form of a monthly benefit (also called an annuity). The type of annuity you elect and, if applicable, your beneficiary's age is also taken into account in calculating your monthly benefit amount. The following ~~annuity~~ options ~~and a lump sum option~~ are available to you:

- **Single Life Annuity**—If you are single, the single life annuity option is the standard form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it in the form of a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end.

~~–~~**50% Joint & Survivor Annuity**—If you are married, the 50% joint and survivor annuity option, with your spouse as the beneficiary, is the standard form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form. Under this option, you receive reduced monthly payments for your lifetime. If your spouse lives longer than you do, after your death, your spouse receives monthly payments equal to 50% of your benefit for his or her lifetime. If you are single, you may not choose this distribution option.~~you may choose this distribution option with a designated beneficiary.~~

- **66-2/3% Joint & Survivor Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your ~~beneficiary~~ spouse lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. If you are single, ~~-~~you may not choose this distribution option.

- **100% Joint & Survivor Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your ~~beneficiary~~ spouse lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. If you are single, you may not choose this distribution option.

- **Five or Ten Year Certain and Life Annuity Option**—Under this option, you will receive a benefit for the rest of your life. However, your pension payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you make this choice, the benefit paid to you during your life will be reduced to provide the guaranteed benefit you select.

- **50% Joint and Survivor Pop-Up Annuity**—Under this option, if you are married, you will receive a reduced monthly pension during your lifetime. If you die before your spouse, your spouse will receive a monthly pension for the remainder of his or her lifetime equal to one-half of the reduced amount you were receiving. If your spouse dies before you, you will receive, beginning on the first day of the month coincident with or next following the death of your

spouse, a monthly benefit equal to the benefit you would have received in the form of a single life annuity without any reduction. -If you are single, you may not choose this distribution option.

- **Lump-Sum**—Under this method you receive the actuarial equivalent of your benefit in a single lump-sum.

If you are married, and you wish to choose (1) the Single Life Annuity, (2) a Certain & Life Annuity, or (3) the Pop-Up Annuity, then you must obtain the written consent of your spouse. ~~If you are married, you can choose the lump sum payment, the single life annuity, the joint and survivor pop up annuity, or any form of distribution with a beneficiary other than your spouse, only if your spouse consents.~~ If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Example of Payment Options:

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65), your spouse was also age 65 and with an accrued benefit of $~~200,000~~1,200.00 per month.

Payment Options	Your Monthly Benefit for Life	Your ~~Spouse's~~ Beneficiary's Monthly Benefit for Life After Your Death
Lump Sum Payment ~~*($171,281)*($200,000)*~~	$0.00	$0.00
Single life annuity	$~~1,331.27~~1,200.00	$0.00
50% annuity	$~~1,223.44~~1,050.00	$~~611.73~~525.00
66-2/3% annuity	$~~1,191.49~~999.60	$~~794.13~~666.40
100% annuity	$ ~~1,132.91~~900.00	$~~1,132.91~~900.00
Five-Year Certain & Life Annuity	$1,182.00	$1,182.00 **
Ten-Year Certain & Life Annuity	$1,140.00	$1,140.00 **
50% Joint & Survivor Pop-Up Annuity	$1,032.00 ***	$516.00

* The exact lump sum amount varies with the age at payment and the interest rate in effect for the current year.

** Beneficiary payments under the Certain & Life Annuity options are payable only through the end of the guarantee period.

*** Under the Pop-Up Annuity option if your spouse dies first, then the monthly payment to you increases to $1,200.00.

Cash-Out Provision

If, at the time of distribution, the actuarial equivalent of your pension benefit does not exceed $5,000, the Plan Administrator has the right to pay you the actuarial equivalent of your accrued benefit in one lump sum.

Your Other Benefits At Retirement

Retiree Medical Benefits

A separate Company-funded account has been established to pay for certain medical benefits of certain retirees and their dependents. Effective July 1, 1994, the Company ceased making contribution to this account. Benefits will continue to be funded through this account until the account balance has been exhausted. At that time, the provision of retiree medical benefits will be made outside the Plan. To be eligible for retiree medical benefits, you must be eligible to retire under the Plan and actually retire from the Company. Any medical coverage to which a retiree and his dependents have become entitled ends upon the death of the retiree.

Please note that the retiree medical benefits described above are governed by the formal plan documents for this program, and this SPD does not alter or expand upon that formal plan document. The Company reserves the right to amend, modify or terminate the program in whole or in part.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of Credited Service, you will not be entitled to a pension benefit and your pension benefit is forfeited.

- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.

- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for support, alimony or marital property rights.

- If you die before your pension benefit begins and are unmarried, no pension benefit is payable to your beneficiary, estate or trust.

- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the Bay State Gas Pension Source~~MySource for Human Resources~~, which handles the day-to-day administration of the Plan at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370

~~MySource for Human Resources~~
~~2300 Discovery Drive~~
~~P.O. Box 785003~~
~~Orlando, FL 32878-5003~~

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under Internal Revenue Code rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the Bay State Gas Company Savings Plan for Operating Employees, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity or term certain forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant. If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under the Plan if you work less than 40 hours per month. If you work 40 or more hours per month, your benefit payments will be suspended until you work less than 40 hours per month. At that time, your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching normal retirement age, you may begin receiving your pension benefit from the Plan.

~~Plan Statements~~

~~Once each year, generally during the first quarter, you will receive a statement showing the value of your pension benefit. It will help you see how your pension benefit grows from year to year. You can also call MySource for Human Resources at **1-888-640-3320** at any time or visit the Web site (**www.mysourceforhr.com**) for information on the value of your accrued benefit.~~

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnisheed, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to your former spouse or dependent. This is known as a "Qualified Domestic Relations Order." As soon as you are aware of any court proceedings that may affect your pension benefit, contact the Bay State Gas Pension Source at **1-877-587-5866**~~MySource for Human Resources at **1-888-640-3320**. To receive a copy of the Plan's procedures that govern QDRO determinations, contact MySource. These procedures will be made available to you or your beneficiary free of charge.~~

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;

- Logging on to the Internet at www.dol.gov/dol/ebsa; or

- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

The Company reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

The Company may make modifications or amendments to the Plan if appropriate or necessary. Amendments will normally not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100% vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits under the Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;

- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, ~~contact MySource for Human Resources at **1-888-640-3320** or~~ contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington, D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000**.

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov.**

Administrative Information

Plan Sponsor

The Plan Sponsor is Bay State Gas Company

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attn: NiSource Inc. and Affiliates Retirement Plan
Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for the Company is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 008. The official Plan name is the Bay State Gas Company Pension Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan administrator or the trustee.

Collective Bargaining Agreement

Your benefits under the Plan are subject to the following collective bargaining agreement:

Location	Union/Local	Term of Collective Bargaining Agreement
Brockton, MA	Utility Workers' Union of America, AFL-CIO-CLC Local 273, Clerical/Technical Unit 995 Belmont Street Brockton, MA 02401	March 31, 2003 – April 1, 2009

Pension Plan for Operating Employees of Bay State Gas Company

Brockton Division

Utility Workers' Union of America, AFL-CIO-CLC, Local Union # 273

Plan # 010

Agreement Period:
03/02/02 - 03/01/08

Summary Plan Description (SPD)

DRAFT FOR DISCUSSION PURPOSES ONLY

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page

As a union employee covered by a collective bargaining agreement between Bay State Gas Company (the "Company") and the Utility Workers' Union of America, AFL-CIO-CLC Local #273 or by any other collective bargaining agreement that provides for participation in the Plan for its employees, you are automatically enrolled in the Pension Plan for Operating Employees of Bay State Gas Company ("Plan") if you satisfy the criteria described in the Eligibility and Enrollment section.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of January 1, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion, subject to the terms of the applicable collective bargaining agreements.

Introduction to the Pension Plan

As a participant, you do not make any contributions to the Plan. The Plan is designed to provide you with a monthly income at retirement, based on your years of Credited Service and your final average pay. The Plan also provides a monthly benefit payable to your eligible spouse in the event of your death.

Under the Plan, your benefits are based on certain factors at the time you retire:

- Your years of Credited Service. Your years of Credited Service are based on your total period of participation in the Plan.
- Your final average pay. Your final average pay is 1/36 of your base pay paid or accrued to you during the highest 36 months in your last 120 months of employment (subject to a Plan cap); and
- Your age at the time you retire.

Benefit Options

The following pension benefit options are available under the Plan:

- A normal retirement pension if you retire on or after your normal retirement age (age 65).
- An early retirement pension if you retire on or after age 55 with at least ten years of Credited Service.
- A deferred vested benefit based on your final average pay and Credited Service up to your termination date if you leave employment with at least five years of Credited Service, but before you are eligible for a normal or early retirement pension.

Your pension benefit is payable for your lifetime. In addition, your eligible spouse may receive a continuing benefit in the event of your death.

Highlights of the Plan

Employee Contribution	None
Company Contribution	Yes; 100%
Vesting	100% vested after 5 years of Credited Service
Eligible Pay	Base pay
When Your Benefit is Paid *(provided you are vested)*	• When you terminate employment • When you reach early or normal retirement age • In the event of your death • April 1 of the year after the year in which your reach age 70-1/2
Retirement Age	• Normal Retirement (age 65) • Early Retirement (age 55 with 10 years of Credited Service)
Payment Options	• Various Monthly Annuity Options • Lump Sum • Rollover
Survivor Benefit	• Monthly Annuity Option

Eligibility and Enrollment

Generally, you are eligible to participate in the Plan if you are an employee of Bay State Gas Company – Brockton Division and you are covered by a collective bargaining agreement between the Company and the Utility Workers of America AFL-CIO-CLC on behalf of Local Union No. 273 covering the period from March 2, 2002 to March 1, 2008, or you meet the eligibility requirements under any other collective bargaining agreement that provides for participation in the Plan for its employees.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts when your employment begins. You are automatically enrolled in the Plan.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your collective bargaining agreement no longer provides for participation in the Plan;
- The Plan ends; or
- You die.

Hour of Service

For Plan purposes, such as eligibility for early retirement and Credited Service for the purpose of calculating your retirement benefit from the Plan, an hour of service means each hour for which you are directly or indirectly paid, or entitled to payment, by the Company as a Plan participant.

Credited Service

Credited Service is used in determining your eligibility for a pension benefit, including vesting, as well as in calculating the amount of your benefit.

Your Credited Service is the number of calendar years in which you have completed at least 1,000 hours of service. An hour of service is each hour for which you are paid for working or are entitled to be paid for work (*e.g.*, vacation and sick days). You also earn Credited Service during any period in which you qualify for benefits under NiSource's Long-Term Disability Plan. Earlier periods of employment with the Company may also count as Credited Service.

If you transfer from an affiliate company, the amount of your pension will be based upon the aggregate period of Credited Service only during your employment with the Company and each affiliate that has adopted the Plan.

For purposes of vesting only, Credited Service will also include your service with the Company and any affiliate during which you were not eligible to participate in the Plan.

Eligible Pay

Your eligible pay is your base pay. All daily and weekly overtime, bonuses, supplementary incentive compensation payments, retirement benefits and other forms of non-recurring compensation are not included.

Final Average Pay

Your final average pay is 1/36 of your base pay paid or accrued to you during the highest 36 consecutive months in your last 120 months of employment. The Plan limits final average pay to a maximum of $60,000, increasing to $65,000 for participants who are active on January 1, 2005.

Break in Service

You have a break in service if you do not return to active employment within 12 months after leaving the Company. The length of broken service is used to determine whether to reinstate service earned before termination if you are later re-employed.

If you were not vested when you terminated employment, you keep all the service if you return to work before the period of broken service equals five years, or if you return to work before the period of broken service is greater than the service you earned before your termination. If the length of your break in service is more than the greater of your period of prior service or five years and you were not vested, you lose credit for all your prior service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when you terminated employment, the service you earned before your termination will be added to the service you earn when you return to work. However the Company does not count the interim period you were away as part of your service.

Break in Service and Leaves

Note that any year in which you receive credit for 500 or more hours is not considered a break in service. When determining if a break in service has occurred, up to 501 hours of service will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours of service will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be more beneficial to you in preventing a break in service.

You will not have a break in service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn Credited Service while the disability continues. Credited Service shall cease to be credited as of the earliest of the date on which your disability ends; the date on which you return to employment, or the date your benefits under the Plan commences.

Transfers

From Affiliate

If you transfer from employment providing coverage under an affiliate's defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will participate in the Plan, subject to the eligibility and enrollment provisions of the Plan.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's defined benefit plan, your accrued benefit under the Plan will be frozen as of the date of your transfer.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

When Your Pension Benefit is Paid

You (or your beneficiary) are entitled to your accrued benefit as soon as possible after:

- You retire at or after age 65, or at or after age 55 with 10 years of Credited Service;
- You leave the Company before retirement with at least five years of Credited Service; or
- You die.

If your accrued benefit is over $5,000 and you terminate employment after completing five or more years of service, you may defer payment to a later date.

Applying for Benefits

If you are retiring, you can call the Bay State Gas Pension Source at **1-877-587-5866** to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your payments begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Upon retirement you can decide to:

- Receive your full accrued benefit if you retire at normal retirement age.

- Receive a reduced accrued benefit, if you retire early, based on your age at the time you retire.

- Defer your benefit to a later date, if you retire early. Your benefit is calculated as of the date you actually retire with any reduction based on the date you later elect to begin receiving benefits. If you wait until your normal retirement date, the reduction does not apply.

Normal Retirement

When you retire at age 65 or later, your monthly pension benefit will be based on your Credited Service (up to a maximum of 45 years) and your final average pay (up to a Plan cap). Your monthly pension benefit will be equal to:

1. 1.25% of your final average pay multiplied by your years of Credited Service not in excess of 45 such years; reduced by

2. any benefit to which you are entitled (or would be entitled if you were to make an election to receive such benefit at time of commencement of your benefit under the Plan) from any other plan maintained by the Company, and which is attributable to service with the Company, for which Credited Service is given under the Plan.

The annual final average pay cap increased to $65,000 effective January 1, 2005. Previously the cap was $60,000.

Example 1: Normal Retirement Benefit, if Single

Bob has worked for the Company for 35 years with a final average pay of $45,000.00. He retires at age 65. His pension benefit is calculated as follows:

1.25% x $45,000.00 x 35 = $19,687.50 per year

$19,687.50 / 12 = $1,640.63 per month

(Minus any benefit to which Bob may be entitled under any Predecessor Plan)

This is the pension benefit payable to Bob if he is single. If he is married, his pension benefit will be paid under a Joint and Survivor Annuity as shown in Example 2.

Example 2: Normal Retirement Benefit, if Married

If you are married and have not chosen (with a notarized, written spousal consent) another method of receiving your pension benefit, your surviving spouse will automatically receive, after your death, a benefit equal to one-half of your pension benefit as a 50% joint and survivor annuity. Your spouse will receive this benefit for the rest of his or her life. Because this arrangement will usually result in benefit payments being paid over a longer period of time than under a single life annuity, the amount of your pension benefit is reduced by a factor, which takes into account your spouse's age and your age at the time of your retirement.

Using the example above, if Bob is married and he and his spouse are age 65, his pension benefit paid as a 50% joint and survivor annuity is calculated as follows:

Single life annuity *(as previously calculated in Example 1)*	$1,640.63
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.875
Total monthly pension benefit payable during Bob's lifetime	$1,435.55
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$717.78

If Bob elected another form of payment, with his wife's consent, as described in the "Forms of Payment" section, the monthly benefit amount would change.

Early Retirement

You may retire as early as the first of the month following or coinciding with the date you reach age 55, if you have completed at least 10 years of Credited Service (early retirement). You may choose to start receiving your pension benefit in any month on or after your early retirement or elect to start receiving your pension benefit at age 65, based upon your final average pay and Credited Service at the time of early retirement.

Your early retirement benefit is based on the same formula used for normal retirement, reduced by a factor that varies by your age and years of Credited Service:

- If you have completed at least 25 years of Credited Service and you retire after age 55 but prior to 60, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 60.

- If you have completed at least 25 years of Credited Service and retire after reaching age 60, there is no reduction factor.

- If you have completed less than 25 years of Credited Service, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 65.

Example 3: Early Retirement with 25 years of Credited Service

Suppose Bob wants to retire at age 60 after 25 years of Credited Service and wants pension benefits to start as soon as he retires. Assume his final average pay is $45,000.00:

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 25 = $14,062.50 per year

Reduction for Early Retirement

Because Bob has 25 years of Credited Service and is retiring at age 60, there is no reduction. Therefore, Bob's monthly pension benefit payable at age 60 is the same as would be payable at 65, or $14,062.50 per year ($1,171.88 per month).

Example 4: Early Retirement with 24 Years of Credited Service

Suppose Bob, in the above example, had only 24 years of Credited Service at the time he elected to retire at age 60.

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 24 = $13,500.00 per year

Reduction for Early Retirement

Bob's normal retirement benefit is reduced 3/10 of 1% for each full month that he retires before he reaches age 65 (59 months in this case).

3/10 of 1% x 59 months = 17.7%

Thus an early retirement reduction factor of 82.3% (1 – 17.7%) will be applied to the Normal Retirement Benefit calculated above.

Bob's normal retirement benefit at age 65 less the reduction for early retirement equals the monthly single life annuity payable to Bob at early retirement.

$13,500.00 x 82.3% = $11,110.50 per year

$11,110.50 / 12 = $ 925.88 per month

The monthly pension annuity benefit payable to Bob at early retirement would be $925.88.

If Bob is married and his spouse is age 58, his early retirement benefit would be paid as follows:

Single life annuity starting at age 60	$925.88
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.865
Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

Supplemental Benefit

The Plan provides eligible employees a supplemental benefit when they elect to take early retirement. This supplemental benefit, also referred to as the "Social Security Bridge" or "Early Retirement Supplement", is intended to provide additional retirement income if you retire on or after age 60 but before age 62.

If you retire on or after age 60 but before age 62, your monthly pension benefit will be increased, but only until you reach age 62 or die, whichever occurs sooner, by an amount equal to 2% of your final average pay (subject to Internal Revenue Code limits) multiplied by your years of Credited Service (but not more than 25 years). However, your temporary supplement may not exceed the Primary Social Security Benefit to which you would be entitled at age 62.

Supplemental Benefit with 24 Years of Credited Service

Lets assume Bob retires at age 60 with 24 years of Credited Service. His final average pay is $45,000.00. Bob's supplemental benefit from age 60 to age 62 would be the lesser of the following:

(1) Supplemental Benefit at Early Retirement

2% x $45,000.00 x 24 yrs = $21,600.00 per year ($1,800.00 per month)

(2) Maximum Supplement – The Primary Social Security Benefit would provide an annual benefit of $13,000.00 for Bob payable at age 62 ($1,083.33 per month). *This is the maximum amount Bob could receive as an early retirement supplemental between ages 60 and 62.*

Thus the total monthly supplemental benefit that Bob would receive would be $1,083.33.

Total Monthly Benefit Payable at Age 60 Early Retirement with 24 years of Service

If Bob is single, the monthly pension benefit (r*educed early retirement benefits plus the supplement benefit*) paid to him as a single life annuity would be:

From Age 60 to 62		**From Age 62 and Over**	
Reduced early retirement benefit	$925.88	Reduced early retirement benefit	$925.88
Plus	+	*Plus*	+
Supplement Benefit	$1,083.33	Supplement benefit	$0.00
Total monthly pension benefit	**$2,009.21**	**Total monthly pension benefit**	**$925.88**

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

If Bob is married and his spouse is age 58 and he elects a 50% joint & survivor annuity, then his early retirement benefit would be paid as follows:

From Age 60 to 62		**From Age 62 and Over**	
Monthly Single Life Annuity	$2,009.20	Monthly Single Life Annuity	$925.88
Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865	Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865
Monthly 50% Joint & Survivor Annuity	$800.89	Monthly 50% Joint & Survivor Annuity	$800.89
Plus	+	*Plus*	+
Early Retirement Supplement (Social Security Bridge Benefit)	$1,083.33	Early Retirement Supplement (Social Security Bridge Benefit)	$0.00
Total monthly pension benefit payable during Bob's lifetime	$1,884.22	Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45	Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

Bob's supplemental benefit is paid only during his lifetime (as a temporary single life annuity), and no further benefits will be payable after his death. If Bob had elected to take his pension payment as a lump sum, however, then the Supplement would also be distributed as a lump sum.

Deferred Vested Pension

If you have completed five or more years of Credited Service with the Company, you may receive a deferred vested pension when you terminate your employment with the Company. You may start your pension benefit as of the later of the first day of the month in which you reach age 65 and the month after you apply for your deferred vested pension. If you have reached age 55 when you terminate employment, you may start your benefit before the first day of the month in which you reach age 65. However, the pension benefit you would be eligible to receive would be reduced by 5/9 of 1% for each full month commencement of your pension benefit precedes you reaching age 65. You also have the option of taking an immediate lump sum cashout regardless of your age at termination.

Death Benefits

Surviving Spouse Benefit

Your surviving spouse is entitled to a "Surviving Spouse Benefit" if you die as an active or terminated employee after having completed at least five years of Credited Service. This benefit would begin on the date you would have attained your early retirement age, if you die before that age, or on the first day of the month following your death if you had reached your early retirement age and then died, and as though you had elected a 50% joint and survivor annuity.

Death After Reaching Your Normal Retirement Date, But Before Retirement or Termination

Your spouse will receive a benefit equal to the monthly survivor pension benefit that would have been payable as though you had retired on the first day of the month immediately prior to your death and the benefit were payable as a 50% joint and survivor annuity. Your spouse will begin receiving the benefit on the first of the month following your death.

Death After Commencement of Benefits

If you die after your pension benefit commences, a death benefit will be paid according to your selected form of payment.

Death Prior to Normal Retirement Date

If you die while an active employee but before your normal retirement date, other than the surviving spouse benefit, no death benefits are payable from the Plan unless you have made contributions to the Plan. In such a case, the death benefit would be equal to your contributions plus interest.

Minimum and Maximum Benefits From the Plan

Minimum Benefits

The minimum benefit payable will be:

- The benefit to which you would have been entitled as in effect for Plan years prior to January 1, 1989; or

- If you were covered under any Predecessor Plan, the amount of your accrued monthly pension benefit under such Predecessor Plan as of the applicable effective date of the consolidation or merger of such Predecessor Plan.

Maximum Benefits

There are certain Internal Revenue Code limits that affect the benefits payable to highly-paid employees, as defined by the IRS. If you are affected, you will be notified.

Payment Options

When you start receiving benefits, in accordance with Plan procedures, you have the following payment forms available to you:

Annuity Payment Forms

The type of annuity you elect, your age, and, if applicable, your beneficiary's age are all taken into account in calculating your pension benefit. The following annuity options are available to you:

- **Single Life Annuity**—If you are single, the single life annuity option is the standard form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it in the form of a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may elect this option with your spouse's consent.

- **50% Annuity**—If you are married, the 50% joint and survivor annuity option, with your spouse as the beneficiary, is the standard form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form. Under this option, you receive reduced monthly payments for your lifetime. If your spouse lives longer than you do, after your death, your spouse receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **50% Pop-Up Annuity**—If you are married, you may elect the 50% pop-up annuity option, with your spouse as the contingent annuitant. If your spouse dies after the date you started receiving your benefit and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. In that case, all benefits would stop at your death. If you die before your spouse, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments

equal to 66-2/3% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

Five or Ten Year Certain and Life Annuity Option

Under this method, you will receive a benefit for the rest of your life. However, your pension payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you make this choice, the benefit paid to you during your life will be reduced to provide the guaranteed benefit you select.

Lump-Sum Payment

You may elect to receive the actuarial equivalent of your accrued benefit in a single lump-sum payment. No further benefits would be payable from the Plan. If the actuarial equivalent of your accrued benefit is $5,000 or less when you leave the Company, the Company automatically pays you a single lump-sum payment after you leave. If you are married at the time you want your benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less.

If you are married, you can choose (1) the single life annuity, (2) the 50% pop-up annuity with your spouse as beneficiary or (3) the five or ten year certain form of distribution, only if your spouse consents. If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Example of Payment Options:

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65), your spouse were also age 65 and with an accrued benefit of $1,200.00 per month.

Payment Options	Your Monthly Benefit for Life	Your Beneficiary's Monthly Benefit After Your Death
Lump Sum Payment *($171,281)**	$0.00	$0.00
Single Life Annuity	$1,200.00	$0.00
50% Joint & Survivor Annuity	$1,050.00	$525.00
66-2/3% Joint & Survivor Annuity	$999.60	$666.40
100% Joint & Survivor Annuity	$900.00	$900.00

Five-Year Certain & Life Annuity	$1,182.00	$1,182.00 **
Ten-Year Certain & Life Annuity	$1,140.00	$1,140.00 **
50% Joint & Survivor Pop-Up Annuity	$1,032.00 ***	$516.00

* The exact lump sum amount varies with the age at payment and the interest rate in effect for the current year.

** Beneficiary payments under the Certain & Life Annuity options are payable only through the end of the guarantee period.

*** Under the Pop-Up Annuity option if your spouse dies first, then the monthly payment to you increases to $1,200.00.

Automatic Cash-Out Provision

If, at the time of payout, the actuarial equivalent of your accrued benefit does not exceed $5,000, the Plan Administrator will automatically pay you the actuarial equivalent of your accrued benefit in one lump sum.

Your Other Benefits At Retirement

Retiree Medical Benefits

A separate Company-funded account has been established to pay for certain medical benefits of certain retirees and their dependents. Effective July 1, 1994, the Company ceased making contribution to this account. Benefits will continue to be funded through this account until the account balance has been exhausted. At that time, the provision of retiree medical benefits will be made outside the Plan. To be eligible for retiree medical benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company. Any medical coverage to which a retiree and his dependents have become entitled ends upon the death of the retiree.

Retiree Life Insurance

To be eligible for retiree life insurance benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company.

Please note that the retiree medical and life insurance benefits described above are governed by the formal plan documents for those benefit programs, and this SPD does not alter or expand upon those formal plan documents. The Company reserves the right to amend, modify or terminate the programs in whole or in part.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of Credited Service, you will not be entitled to a pension benefit and your pension benefit is forfeited.

- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.

- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights.

- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;

- References to the Plan provision(s) on which the denial is based;

- A description of any additional material or information that is necessary to complete the claim; and

- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the Bay State Gas Pension Source, which handles the day-to-day administration of the Plan at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under Internal Revenue Code rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the Bay State Gas Company Savings Plan for Operating Employees, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity or term certain forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant. If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under the Plan under the same option if you work less than 40 hours (or 8 days) per month. If you work 40 or more hours (or 8 or more days) per month, your benefit payments will be suspended until you work less than 40 hours (or 8 days) per month. When you subsequently leave the Company or retire, your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours (or 8 or more days) per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours (or 8 days) per month on and after reaching normal retirement age, you may begin receiving your pension benefit from the Plan.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnisheed, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to your former spouse or dependent. This is known as a "Qualified Domestic Relations Order." As soon as you are aware of any court proceedings that may affect your pension benefit, contact the Bay State Gas Pension Source at **1-877-587-5866**.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you, and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including

insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;

- Logging on to the Internet at www.dol.gov/dol/ebsa; or

- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

The Company reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

The Company may make modifications or amendments to the Plan if appropriate or necessary. Amendments will normally not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100% vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits under the Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000.**

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Administrative Information

Plan Sponsor

The Plan Sponsor is Bay State Gas Company

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attn: NiSource Inc. and Affiliates Retirement Plan
Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for the Company is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 010. The official Plan name is the Pension Plan for Operating Employees of Bay State Gas Company.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan administrator or the trustee.

Collective Bargaining Agreement

Your benefits under the Plan are subject to the following collective bargaining agreement:

Location	Union/Local	Term of Collective Bargaining Agreement
Brockton, MA	Utility Workers' Union of America, AFL-CIO-CLC Local 273 995 Belmont Street Brockton, MA 02401	March 02, 2002 – March 1, 2008

Pension Plan for Operating Employees of Bay State Gas Company

Lawrence Division

International Brotherhood of Electrical Workers
Local Union # 326

Plan # 010

Agreement Period:
06/19/00 - 06/18/05

Summary Plan Description (SPD)

DRAFT FOR DISCUSSION PURPOSES ONLY

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As a union employee covered by a collective bargaining agreement between Bay State Gas Company (the "Company") and the International Brotherhood of Electrical Workers, Local #326 or by any other collective bargaining agreement that provides for participation in the Plan for its employees, you are automatically enrolled in the Pension Plan for Operating Employees of Bay State Gas Company ("Plan") if you satisfy the criteria described in the Eligibility and Enrollment section.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of January 1, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion, subject to the terms of the applicable collective bargaining agreements.

Introduction to the Pension Plan

As a participant, you do not make any contributions to the Plan. The Plan is designed to provide you with a monthly income at retirement, based on your years of Credited Service and your final average pay. The Plan also provides a monthly benefit payable to your eligible spouse in the event of your death.

Under the Plan, your benefits are based on certain factors at the time you retire:

- Your years of Credited Service. Your years of Credited Service are based on your total period of participation in the Plan.

- Your final average pay. Your final average pay is 1/36 of your base pay paid or accrued to you during the highest 36 months in your last 120 months of employment (subject to a Plan cap); and

- Your age at the time you retire.

Benefit Options

The following pension benefit options are available under the Plan:

- A normal retirement pension if you retire on or after your normal retirement age (age 65).

- An early retirement pension if you retire on or after age 55 with at least ten years of Credited Service.

- A deferred vested benefit based on your final average pay and Credited Service up to your termination date if you leave employment with at least five years of Credited Service, but before you are eligible for a normal or early retirement pension.

Your pension benefit is payable for your lifetime. In addition, your eligible spouse may receive a continuing benefit in the event of your death.

Highlights of the Plan

Employee Contribution	None
Company Contribution	Yes; 100%
Vesting	100% vested after 5 years of Credited Service
Eligible Pay	Base pay
When Your Benefit is Paid *(provided you are vested)*	• When you terminate employment • When you reach early or normal retirement age • In the event of your death • April 1 of the year after the year in which your reach age 70-1/2
Retirement Age	• Normal Retirement (age 65) • Early Retirement (age 55 with 10 years of Credited Service)
Payment Options	• Various Monthly Annuity Options • Lump Sum • Rollover
Survivor Benefit	• Monthly Annuity Option

Eligibility and Enrollment

Generally, you are eligible to participate in the Plan if you are an employee of Bay State Gas Company – Lawrence Division and you are covered by a collective bargaining agreement between the Company and the International Brotherhood of Electrical Workers Local #326 covering the period from June 19, 2000 to June 18, 2005, or you meet the eligibility requirements under any other collective bargaining agreement that provides for participation in the Plan for its employees.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts when your employment begins. You are automatically enrolled in the Plan.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your collective bargaining agreement no longer provides for participation in the Plan;
- The Plan ends; or
- You die.

Hour of Service

For Plan purposes, such as eligibility for early retirement and Credited Service for the purpose of calculating your retirement benefit from the Plan, an hour of service means each hour for which you are directly or indirectly paid, or entitled to payment, by the Company as a Plan participant.

Credited Service

Credited Service is used in determining your eligibility for a pension benefit, including vesting, as well as in calculating the amount of your benefit.

Your Credited Service is the number of calendar years in which you have completed at least 1,000 hours of service. An hour of service is each hour for which you are paid for working or are entitled to be paid for work (*e.g.*, vacation and sick days). You also earn Credited Service during any period in which you qualify for benefits under NiSource's Long-Term Disability Plan. Earlier periods of employment with the Company may also count as Credited Service.

If you transfer from an affiliate company, the amount of your pension will be based upon the aggregate period of Credited Service only during your employment with the Company and each affiliate that has adopted the Plan.

For purposes of vesting only, Credited Service will also include your service with the Company and any affiliate during which you were not eligible to participate in the Plan.

Eligible Pay

Your eligible pay is your base pay. All daily and weekly overtime, bonuses, supplementary incentive compensation payments, retirement benefits and other forms of non-recurring compensation are not included.

Final Average Pay

Your final average pay is 1/36 of your base pay paid or accrued to you during the highest 36 consecutive months in your last 120 months of employment. The Plan limits final average pay to a maximum of $51,000.

Break in Service

You have a break in service if you do not return to active employment within 12 months after leaving the Company. The length of broken service is used to determine whether to reinstate service earned before termination if you are later re-employed.

If you were not vested when you terminated employment, you keep all the service if you return to work before the period of broken service equals five years, or if you return to work before the period of broken service is greater than the service you earned before your termination. If the length of your break in service is more than the greater of your period of prior service or five years and you were not vested, you lose credit for all your prior service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when you terminated employment, the service you earned before your termination will be added to the service you earn when you return to work. However the Company does not count the interim period you were away as part of your service.

Break in Service and Leaves

Note that any year in which you receive credit for 500 or more hours is not considered a break in service. When determining if a break in service has occurred, up to 501 hours of service will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours of service will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be more beneficial to you in preventing a break in service.

You will not have a break in service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn Credited Service while the disability continues. Credited Service shall cease to be credited as of the earliest of the date on which your disability ends; the date on which you return to employment, or the date your benefits under the Plan commence.

Transfers

From Affiliate

If you transfer from employment providing coverage under an affiliate's defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will participate in the Plan, subject to the eligibility and enrollment provisions of the Plan.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's defined benefit plan, your accrued benefit under the Plan will be frozen as of the date of your transfer.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

When Your Pension Benefit is Paid

You (or your beneficiary) are entitled to your accrued benefit as soon as possible after:

- You retire at or after age 65, or at or after age 55 with 10 years of Credited Service;
- You leave the Company before retirement with at least five years of Credited Service; or
- You die.

If your accrued benefit is over $5,000 and you terminate employment after completing five or more years of Credited Service, you may defer payment to a later date.

Applying for Benefits

If you are retiring, you can call the Bay State Gas Pension Source at **1-877-587-5866** to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your payments begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Upon retirement you can decide to:

- Receive your full accrued benefit if you retire at normal retirement age.
- Receive a reduced accrued benefit, if you retire early, based on your age at the time you retire.
- Defer your benefit to a later date, if you retire early. Your benefit is calculated as of the date you actually retire with any reduction based on the date you later elect to begin receiving benefits. If you wait until your normal retirement date, the reduction does not apply.

Normal Retirement

When you retire at age 65 or later, your monthly pension benefit will be based on your Credited Service (up to a maximum of 45 years) and your final average pay (up to a Plan cap). Your monthly pension benefit will be equal to:

1. 1.25% of your final average pay multiplied by yours years of Credited Service not in excess of 45 such years; reduced by

2. any benefit to which you are entitled (or would be entitled if you were to make an election to receive such benefit at time of commencement of your benefit under the Plan) from any other plan maintained by the Company, and which is attributable to service with the Company, for which Credited Service is given under the Plan.

The annual final average pay cap is $51,000.

Example 1: Normal Retirement Benefit, if Single

Bob has worked for the Company for 35 years with a final average pay of $45,000.00. He retires at age 65. His pension benefit is calculated as follows:

1.25% x $45,000.00 x 35	=	$19,687.50 per year
$19,687.50 / 12	=	$ 1,640.63 per month

(Minus any benefit to which Bob may be entitled under any Predecessor Plan)

This is the pension benefit payable to Bob if he is single. If he is married, his pension benefit will be paid under a Joint and Survivor Annuity as shown in Example 2.

Example 2: Normal Retirement Benefit, if Married

If you are married and have not chosen (with a notarized, written spousal consent) another method of receiving your pension benefit, your surviving spouse will automatically receive, after your death, a benefit equal to one-half of your pension benefit as a 50% joint and survivor annuity. Your spouse will receive this benefit for the rest of his or her life. Because this arrangement will usually result in benefit payments being paid over a longer period of time than under a single life annuity, the amount of your pension benefit is reduced by a factor, which takes into account your spouse's age and your age at the time of your retirement.

Using the example above, if Bob is married and he and his spouse are age 65, his pension benefit paid as a 50% joint and survivor annuity is calculated as follows:

Single life annuity *(as previously calculated in Example 1)*	$1,640.63
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.875
Total monthly pension benefit payable during Bob's lifetime	$1,435.55
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$717.78

If Bob elected another form of payment, with his wife's consent, as described in the "Forms of Payment" section, the monthly benefit amount would change.

Early Retirement

You may retire as early as the first of the month following or coinciding with the date you reach age 55, if you have completed at least 10 years of Credited Service (early retirement). You may choose to start receiving your pension benefit in any month on or after your early retirement or elect to start receiving your pension benefit at age 65, based upon your final average pay and Credited Service at the time of early retirement.

Your early retirement benefit is based on the same formula used for normal retirement, reduced by a factor that varies by your age and years of Credited Service:

- If you have completed at least 25 years of Credited Service and you retire after age 55 but prior to 60, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 60.

- If you have completed at least 25 years of Credited Service and retire after reaching age 60, there is no reduction factor.

- If you have completed less than 25 years of Credited Service, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 65.

Example 3: Early Retirement with 25 years of Credited Service

Suppose Bob wants to retire at age 60 after 25 years of Credited Service and wants pension benefits to start as soon as he retires. Assume his final average pay is $45,000.00:

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 25 = $14,062.50 per year

Reduction for Early Retirement

Because Bob has 25 years of Credited Service and is retiring at age 60, there is no reduction. Therefore, Bob's monthly pension benefit payable at age 60 is the same as would be payable at 65, or $14,062.50 per year ($1,171.88 per month).

Example 4: Early Retirement with 24 Years of Credited Service

Suppose Bob, in the above example, had only 24 years of Credited Service at the time he elected to retire at age 60.

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 24 = $13,500.00 per year

Reduction for Early Retirement

Bob's normal retirement benefit is reduced 3/10 of 1% for each full month that he retires before he reaches age 65 (59 months in this case).

3/10 of 1% x 59 months = 17.7%

Thus an early retirement reduction factor of 82.3% (1 – 17.7%) will be applied to the Normal Retirement Benefit calculated above.

Bob's normal retirement benefit at age 65 less the reduction for early retirement equals the monthly single life annuity payable to Bob at early retirement.

$13,500.00 x 82.3% = $11,110.50 per year

$11,110.50 / 12 = $ 925.88 per month

The monthly pension annuity benefit payable to Bob at early retirement would be $925.88.

If Bob is married and his spouse is age 58, his early retirement benefit would be paid as follows:

Single life annuity starting at age 60	$925.88
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.865
Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her	$400.45

lifetime	

Supplemental Benefit

The Plan provides eligible employees a supplemental benefit when they elect to take early retirement. This supplemental benefit, also referred to as the "Social Security Bridge" or "Early Retirement Supplement", is intended to provide additional retirement income if you retire on or after age 60 but before age 62.

If you retire on or after age 60 but before age 62, your monthly pension benefit will be increased, but only until you reach age 62 or die, whichever occurs sooner, by an amount equal to 2% of your final average pay multiplied by your years of Credited Service (but not more than 25 years). However, your temporary supplement may not exceed the Primary Social Security Benefit to which you would be entitled at age 62.

Supplemental Benefit with 24 Years of Credited Service

Lets assume Bob retires at age 60 with 24 years of Credited Service. His final average pay is $45,000.00. Bob's supplemental benefit from age 60 to age 62 would be the lesser of the following:

(1) Supplemental Benefit at Early Retirement

2% x $45,000.00 x 24 yrs = $21,600.00 per year ($1,800.00 per month)

(2) Maximum Supplement – The Primary Social Security Benefit would provide an annual benefit of $13,000.00 for Bob payable at age 62 ($1,083.33 per month). *This is the maximum amount Bob could receive as an early retirement supplemental benefit between ages 60 and 62.*

Thus the total monthly supplemental benefit that Bob would receive would be $1,083.33.

Total Monthly Benefit Payable at Age 60 Early Retirement with 24 years of Service

If Bob is single, the monthly pension benefit (r*educed early retirement benefits plus the supplemental benefit*) paid to him as a single life annuity would be:

From Age 60 to 62		**From Age 62 and Over**	
Reduced early retirement benefit	$925.88	Reduced early retirement benefit	$925.88
Plus	+	*Plus*	+
Supplement Benefit	$1,083.33	Supplement benefit	$0.00
Total monthly pension benefit	**$2,009.21**	**Total monthly pension benefit**	**$925.88**

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental

benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

If Bob is married and his spouse is age 58 and he elects a 50% joint & survivor annuity, then his early retirement benefit would be paid as follows:

From Age 60 to 62		**From Age 62 and Over**	
Monthly Single Life Annuity	$925.88	Monthly Single Life Annuity	$925.88
Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865	Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865
Monthly 50% Joint & Survivor Annuity	$800.89	Monthly 50% Joint & Survivor Annuity	800.89
Plus	+	*Plus*	+
Early Retirement Supplement (Social Security Bridge Benefit)	$1,083.33	Early Retirement Supplement (Social Security Bridge Benefit)	$0.00
Total monthly pension benefit payable during Bob's lifetime	$1,884.22	Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45	Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

Bob's supplemental benefit is paid only during his lifetime (as a temporary single life annuity), and no further benefits will be payable after his death. If Bob had elected to take his pension payment as a lump sum, however, then the Supplement would also be distributed as a lump sum.

Deferred Vested Pension

If you have completed five or more years of Credited Service with the Company, you may receive a deferred vested pension when you terminate your employment with the Company. You may start your pension benefit as of the later of the first day of the month in which you reach age 65 and the month after you apply for your deferred vested pension. If you have reached age 55 when you terminate employment, you may start your benefit before the first day of the month in which you reach age 65. However, the pension benefit you would be eligible to receive would be reduced by

5/9 of 1% for each full month commencement of your pension benefit precedes you reaching age 65. You also have the option of taking an immediate lump sum cashout regardless of your age at termination.

Death Benefits

Surviving Spouse Benefit

Your surviving spouse is entitled to a "Surviving Spouse Benefit" if you die as an active or terminated employee after having completed at least five years of Credited Service. This benefit would begin on the date you would have attained your early retirement age, if you die before that age, or on the first day of the month following your death if you had reached your early retirement age and then died, and as though you had elected a 50% joint and survivor annuity.

Death After Reaching Your Normal Retirement Date, But Before Retirement or Termination

Your spouse will receive a benefit equal to the monthly survivor pension benefit that would have been payable as though you had retired on the first day of the month immediately prior to your death and the benefit were payable as a 50% joint and survivor annuity. Your spouse will begin receiving the benefit on the first of the month following your death.

Death After Commencement of Benefits

If you die after your pension benefit commences, a death benefit will be paid according to your selected form of payment.

Death Prior to Normal Retirement Date

If you die while an active employee but before your normal retirement date, other than the surviving spouse benefit, no death benefits are payable from the Plan unless you have made contributions to the Plan. In such a case, the death benefit would be equal to your contributions plus interest.

Minimum and Maximum Benefits From the Plan

Minimum Benefits

The minimum benefit payable will be:

- The benefit to which you would have been entitled as in effect for Plan years prior to January 1, 1989; or

- If you were covered under any Predecessor Plan, the amount of your accrued monthly pension benefit under such Predecessor Plan as of the applicable effective date of the consolidation or merger of such Predecessor Plan.

Maximum Benefits

There are certain Internal Revenue Code limits that affect the benefits payable to highly-paid employees, as defined by the IRS. If you are affected, you will be notified.

Payment Options

When you start receiving benefits, in accordance with Plan procedures, you have the following payment forms available to you:

Annuity Payment Forms

The type of annuity you elect, your age, and, if applicable, your beneficiary's age are all taken into account in calculating your pension benefit. The following annuity options are available to you:

- **Single Life Annuity**—If you are single, the single life annuity option is the standard form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it in the form of a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may elect this option with your spouse's consent.

- **50% Annuity**—If you are married, the 50% joint and survivor annuity option, with your spouse as the beneficiary, is the standard form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form. Under this option, you receive reduced monthly payments for your lifetime. If your spouse lives longer than you do, after your death, your spouse receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **50% Pop-Up Annuity**—If you are married, you may elect the 50% pop-up annuity option, with your spouse as the contingent annuitant. If your spouse dies after the date you started receiving your benefit and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. If you die before your spouse, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments

equal to the benefit you were receiving for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

Five or Ten Year Certain and Life Annuity Option

Under this method, you will receive a benefit for the rest of your life. However, your pension payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you make this choice, the benefit paid to you during your life will be reduced to provide the guaranteed benefit you select.

Lump-Sum Payment

You may elect to receive the actuarial equivalent of your accrued benefit in a single lump-sum payment. No further benefits would be payable from the Plan. If the actuarial equivalent of your accrued benefit is $5,000 or less when you leave the Company, the Company automatically pays you a single lump-sum payment after you leave. If you are married at the time you want your benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less.

If you are married, you can choose (1) the single life annuity, (2) the 50% pop-up annuity with your spouse as beneficiary or (3) the five or ten year certain form of distribution, only if your spouse consents. If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Example of Payment Options:

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65), your spouse were also age 65 and with an accrued benefit of $1,200.00 per month.

Payment Options	Your Monthly Benefit for Life	Your Beneficiary's Monthly Benefit After Your Death
Lump Sum Payment *($171,281)**	$0.00	$0.00
Single Life Annuity	$1,200.00	$0.00
50% Joint & Survivor Annuity	$1,050.00	$525.00
66-2/3% Joint & Survivor Annuity	$999.60	$666.40
100% Joint & Survivor Annuity	$900.00	$900.00
Five-Year Certain & Life Annuity	$1,182.00	$1,182.00 **
Ten-Year Certain & Life Annuity	$1,140.00	$1,140.00 **
50% Joint & Survivor Pop-Up Annuity	$1,032.00 ***	$516.00

* The exact lump sum amount varies with the age at payment and the interest rate in effect for the current year.

** Beneficiary payments under the Certain & Life Annuity options are payable only through the end of the guarantee period.

*** Under the Pop-Up Annuity option if your spouse dies first, then the monthly payment to you increases to $1,200.00.

Automatic Cash-Out Provision

If, at the time of payout, the actuarial equivalent of your accrued benefit does not exceed $5,000, the Plan administrator will automatically pay you the actuarial equivalent of your accrued benefit in one lump sum.

Your Other Benefits At Retirement

Retiree Medical Benefits

A separate Company-funded account has been established to pay for certain medical benefits of certain retirees and their dependents. Effective July 1, 1994, the Company ceased making contribution to this account. Benefits will continue to be funded through this account until the account balance has been exhausted. At that time, the provision of retiree medical benefits will be made outside the Plan. To be eligible for retiree medical benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company. Any medical coverage to which a retiree and his dependents have become entitled ends upon the death of the retiree.

Retiree Life Insurance

To be eligible for retiree life insurance benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company.

Please note that the retiree medical and life insurance benefits described above are governed by the formal plan documents for those benefit programs, and this SPD does not alter or expand upon those formal plan documents. The Company reserves the right to amend, modify or terminate the programs in whole or in part.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of Credited Service, you will not be entitled to a pension benefit and your pension benefit is forfeited.

- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.

- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights.

- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;

- References to the Plan provision(s) on which the denial is based;

- A description of any additional material or information that is necessary to complete the claim; and

- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the Bay State Gas Pension Source, which handles the day-to-day administration of the Plan at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under Internal Revenue Code rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity or term certain forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant. If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under the Plan under the same option if you work less than 40 hours (or 8 days) per month. If you work 40 or more hours (or 8 or more days) per month, your benefit payments will be suspended until you work less than 40 hours (or 8 days) per month. When you subsequently leave the Company or retire, your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours (or 8 or more days) per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours (or 8 days) per month on and after reaching normal retirement age, you may begin receiving your pension benefit from the Plan.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnisheed, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to your former spouse or dependent. This is known as a "Qualified Domestic Relations Order." As soon as you are aware of any court proceedings that may affect your pension benefit, contact the Bay State Gas Pension Source at **1-877-587-5866**.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you, and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;
- Logging on to the Internet at www.dol.gov/dol/ebsa; or
- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

The Company reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

The Company may make modifications or amendments to the Plan if appropriate or necessary. Amendments will normally not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100% vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits under the Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and

- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000.**

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Administrative Information

Plan Sponsor

The Plan Sponsor is Bay State Gas Company.

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attn: NiSource Inc. and Affiliates Retirement Plan
Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for the Company is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 010. The official Plan name is the Pension Plan for Operating Employees of Bay State Gas Company.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan administrator or the trustee.

Collective Bargaining Agreement

Your benefits under the Plan are subject to the following collective bargaining agreement:

Location	Union/Local	Term of Collective Bargaining Agreement
Lawrence, MA	International Brotherhood of Electrical Workers Local 326 55 Marston Street Lawrence, MA 01841	June 19, 2000 – June 18, 2005

Pension Plan for Operating Employees of Bay State Gas Company

Northampton Division

International Brotherhood of Electrical Workers
Local Union # 486

Plan # 010

Agreement Period:
06/19/04 - 06/18/10

Summary Plan Description (SPD)

DRAFT FOR DISCUSSION PURPOSES ONLY

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As a union employee covered by a collective bargaining agreement between Bay State Gas Company (the "Company") and the International Brotherhood of Electrical Workers, Local 486 or by any other collective bargaining agreement that provides for participation in the Plan for its employees, you are automatically enrolled in the Pension Plan for Operating Employees of Bay State Gas Company ("Plan") if you satisfy the criteria described in the Eligibility and Enrollment section.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of June 19, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion, subject to the terms of the applicable collective bargaining agreements.

Introduction to the Pension Plan

As a participant, you do not make any contributions to the Plan. The Plan is designed to provide you with a monthly income at retirement, based on your years of Credited Service and your final average pay. The Plan also provides a monthly benefit payable to your eligible spouse in the event of your death.

Under the Plan, your benefits are based on certain factors at the time you retire:

- Your years of Credited Service. Your years of Credited Service are based on your total period of participation in the Plan.

- Your final average pay. Your final average pay is 1/36 of your base pay paid or accrued to you during the highest 36 months in your last 120 months of employment (subject to a Plan cap); and

- Your age at the time you retire.

Benefit Options

The following pension benefit options are available under the Plan:

- A normal retirement pension if you retire on or after your normal retirement age (age 65).

- An early retirement pension if you retire on or after age 55 with at least ten years of Credited Service.

- A deferred vested benefit based on your final average pay and Credited Service up to your termination date if you leave employment with at least five years of Credited Service, but before you are eligible for a normal or early retirement pension.

Your pension benefit is payable for your lifetime. In addition, your eligible spouse may receive a continuing benefit in the event of your death.

Highlights of the Plan

Employee Contribution	None
Company Contribution	Yes; 100%
Vesting	100% vested after 5 years of Credited Service
Eligible Pay	Base pay
When Your Benefit is Paid *(provided you are vested)*	• When you terminate employment • When you reach early or normal retirement age • In the event of your death • April 1 of the year after the year in which your reach age 70-1/2
Retirement Age	• Normal Retirement (age 65) • Early Retirement (age 55 with 10 years of Credited Service)
Payment Options	• Various Monthly Annuity Options • Lump Sum • Rollover
Survivor Benefit	• Monthly Annuity Option

Eligibility and Enrollment

Generally, you are eligible to participate in the Plan if you are an employee of Bay State Gas Company – Northampton Division and you are covered by a collective bargaining agreement between the Company and the International Brotherhood of Electrical Workers' Local 486 covering the period from June 19, 2004 to June 18, 2010, or you meet the eligibility requirements under any other collective bargaining agreement that provides for participation in the Plan for its employees.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts when your employment begins. You are automatically enrolled in the Plan.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your collective bargaining agreement no longer provides for participation in the Plan;
- The Plan ends; or
- You die.

Hour of Service

For Plan purposes, such as eligibility for early retirement and Credited Service for the purpose of calculating your retirement benefit from the Plan, an hour of service means each hour for which you are directly or indirectly paid, or entitled to payment, by the Company as a Plan participant.

Credited Service

Credited Service is used in determining your eligibility for a pension benefit, including vesting, as well as in calculating the amount of your benefit.

Your Credited Service is the number of calendar years in which you have completed at least 1,000 hours of service. An hour of service is each hour for which you are paid for working or are entitled to be paid for work (*e.g.*, vacation and sick days). You also earn Credited Service during any period in which you qualify for benefits under NiSource's Long-Term Disability Plan. Earlier periods of employment with the Company may also count as Credited Service.

If you transfer from an affiliate company, the amount of your pension will be based upon the aggregate period of Credited Service only during your employment with the Company and each affiliate that has adopted the Plan.

For purposes of vesting only, Credited Service will also include your service with the Company and any affiliate during which you were not eligible to participate in the Plan.

Eligible Pay

Your eligible pay is your base pay. All daily and weekly overtime, bonuses, supplementary incentive compensation payments, retirement benefits and other forms of non-recurring compensation are not included.

Final Average Pay

Your final average pay is 1/36 of your base pay paid or accrued to you during the highest 36 consecutive months in your last 120 months of employment. The Plan limits final average pay to a maximum of $60,000. This limit will be increased to $65,000 effective June 19, 2006, and then to $70,000 effective June 19, 2009.

Break in Service

You have a break in service if you do not return to active employment within 12 months after leaving the Company. The length of broken service is used to determine whether to reinstate service earned before termination if you are later re-employed.

If you were not vested when you terminated employment, you keep all the service if you return to work before the period of broken service equals five years, or if you return to work before the period of broken service is greater than the service you earned before your termination. If the length of your break in service is more than the greater of your period of prior service or five years and you were not vested, you lose credit for all your prior service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when you terminated employment, the service you earned before your termination will be added to the service you earn when you return to work. However the Company does not count the interim period you were away as part of your service.

Break in Service and Leaves

Note that any year in which you receive credit for 500 or more hours is not considered a break in service. When determining if a break in service has occurred, up to 501 hours of service will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours of service will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be more beneficial to you in preventing a break in service.

You will not have a break in service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn Credited Service while the disability continues. Credited Service shall cease to be credited as of the earliest of the date on which your disability ends; the date on which you return to employment, or the date your benefits under the Plan commences.

Transfers

From Affiliate

If you transfer from employment providing coverage under an affiliate's defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will participate in the Plan, subject to the eligibility and enrollment provisions of the Plan.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's defined benefit plan, your accrued benefit under the Plan will be frozen as of the date of your transfer.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

When Your Pension Benefit is Paid

You (or your beneficiary) are entitled to your accrued benefit as soon as possible after:

- You retire at or after age 65, or at or after age 55 with 10 years of Credited Service;
- You leave the Company before retirement with at least five years of Credited Service; or
- You die.

If your accrued benefit is over $5,000 and you terminate employment after completing five or more years of service, you may defer payment to a later date.

Applying for Benefits

If you are retiring, you can call the Bay State Gas Pension Source at **1-877-587-5866** to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your payments begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Upon retirement you can decide to:

- Receive your full accrued benefit if you retire at normal retirement age.

- Receive a reduced accrued benefit, if you retire early, based on your age at the time you retire.

- Defer your benefit to a later date, if you retire early. Your benefit is calculated as of the date you actually retire with any reduction based on the date you later elect to begin receiving benefits. If you wait until your normal retirement date, the reduction does not apply.

Normal Retirement

When you retire at age 65 or later, your monthly pension benefit will be based on your Credited Service (up to a maximum of 45 years) and your final average pay (up to a Plan cap). Your monthly pension benefit will be equal to:

1. 1.25% of your final average pay multiplied by your years of Credited Service not in excess of 45 such years; reduced by

2. any benefit to which you are entitled (or would be entitled if you were to make an election to receive such benefit at time of commencement of your benefit under the Plan) from any other plan maintained by the Company, and which is attributable to service with the Company, for which Credited Service is given under the Plan.

The annual final average pay cap is $60,000. Effective June 19, 2006 the annual cap will be increased to $65,000, and then to $70,000 effective June 19, 2009.

Example 1: Normal Retirement Benefit, if Single

Bob has worked for the Company for 35 years with a final average pay of $45,000.00. He retires at age 65. His pension benefit is calculated as follows:

1.25% x $45,000.00 x 35	=	$19,687.50 per year
$19,687.50 / 12	=	$ 1,640.63 per month

(Minus any benefit to which Bob may be entitled under any Predecessor Plan)

This is the pension benefit payable to Bob if he is single. If he is married, his pension benefit will be paid under a Joint and Survivor Annuity as shown in Example 2.

Example 2: Normal Retirement Benefit, if Married

If you are married and have not chosen (with a notarized, written spousal consent) another method of receiving your pension benefit, your surviving spouse will automatically receive, after your death, a benefit equal to one-half of your pension benefit as a 50% joint and survivor annuity. Your spouse will receive this benefit for the rest of his or her life. Because this arrangement will usually result in benefit payments being paid over a longer period of time than under a single life annuity, the amount of your pension benefit is reduced by a factor, which takes into account your spouse's age and your age at the time of your retirement.

Using the example above, if Bob is married and he and his spouse are age 65, his pension benefit paid as a 50% joint and survivor annuity is calculated as follows:

Single life annuity *(as previously calculated in Example 1)*	$1,640.63
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.875
Total monthly pension benefit payable during Bob's lifetime	$1,435.55
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$717.78

If Bob elected another form of payment, with his wife's consent, as described in the "Forms of Payment" section, the monthly benefit amount would change.

Early Retirement

You may retire as early as the first of the month following or coinciding with the date you reach age 55, if you have completed at least 10 years of Credited Service (early retirement). You may choose to start receiving your pension benefit in any month on or after your early retirement or elect to start receiving your pension benefit at age 65, based upon your final average pay and Credited Service at the time of early retirement.

Your early retirement benefit is based on the same formula used for normal retirement, reduced by a factor that varies by your age and years of Credited Service:

- If you have completed at least 25 years of Credited Service and you retire after age 55 but prior to 60, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 60.

- If you have completed at least 25 years of Credited Service and retire after reaching age 60, there is no reduction factor.

- If you have completed less than 25 years of Credited Service, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 65.

Example 3: Early Retirement with 25 years of Credited Service

Suppose Bob wants to retire at age 60 after 25 years of Credited Service and wants pension benefits to start as soon as he retires. Assume his final average pay is $45,000.00:

<u>Bob's Normal Retirement Benefit at Age 65</u>

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 25 = $14,062.50 per year

Reduction for Early Retirement

Because Bob has 25 years of Credited Service and is retiring at age 60, there is no reduction. Therefore, Bob's monthly pension benefit payable at age 60 is the same as would be payable at 65, or $14,062.50 per year ($1,171.88 per month).

Example 4: Early Retirement with 24 Years of Credited Service

Suppose Bob, in the above example, had only 24 years of Credited Service at the time he elected to retire at age 60.

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 24 = $13,500.00 per year

Reduction for Early Retirement

Bob's normal retirement benefit is reduced 3/10 of 1% for each full month that he retires before he reaches age 65 (59 months in this case).

3/10 of 1% x 59 months = 17.7%

Thus an early retirement reduction factor of 82.3% (1 – 17.7%) will be applied to the Normal Retirement Benefit calculated above.

Bob's normal retirement benefit at age 65 less the reduction for early retirement equals the monthly single life annuity payable to Bob at early retirement.

$13,500.00 x 82.3% = $11,110.50 per year

$11,110.50 / 12 = $ 925.88 per month

The monthly pension annuity benefit payable to Bob at early retirement would be $925.88.

If Bob is married and his spouse is age 58, his early retirement benefit would be paid as follows:

Single life annuity starting at age 60	$925.88
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.865
Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

Supplemental Benefit

The Plan provides eligible employees a supplemental benefit when they elect to take early retirement. This supplemental benefit, also referred to as the "Social Security Bridge" or "Early Retirement Supplement", is intended to provide additional retirement income if you retire on or after age 60 but before age 62.

If you retire on or after age 60 but before age 62, your monthly pension benefit will be increased, but only until you reach age 62 or die, whichever occurs sooner, by an amount equal to 2% of your final average pay (subject to Internal Revenue Code limits) multiplied by your years of Credited Service (but not more than 25 years). However, your temporary supplement may not exceed the Primary Social Security Benefit to which you would be entitled at age 62.

Supplemental Benefit with 24 Years of Credited Service

Lets assume Bob retires at age 60 with 24 years of Credited Service. His final average pay is $45,000.00. Bob's supplemental benefit from age 60 to age 62 would be the lesser of the following:

(1) Supplemental Benefit at Early Retirement

2% x $45,000.00 x 24 yrs = $21,600.00 per year ($1,800.00 per month)

(2) Maximum Supplement – The Primary Social Security Benefit would provide an annual benefit of $13,000.00 for Bob payable at age 62 ($1,083.33 per month). *This is the maximum amount Bob could receive as an early retirement supplemental benefit between ages 60 and 62.*

Thus the total monthly supplemental benefit that Bob would receive would be $1,083.33.

Total Monthly Benefit Payable at Age 60 Early Retirement with 24 years of Service

If Bob is single, the monthly pension benefit (r*educed early retirement benefits plus the supplemental benefit*) paid to him as a single life annuity would be:

From Age 60 to 62		**From Age 62 and Over**	
Reduced early retirement benefit	$925.88	Reduced early retirement benefit	$925.88
Plus	+	*Plus*	+
Supplement Benefit	$1,083.33	Supplement benefit	$0.00
Total monthly pension benefit	**$2,009.21**	**Total monthly pension benefit**	**$925.88**

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

If Bob is married and his spouse is age 58 and he elects a 50% joint & survivor annuity, then his early retirement benefit would be paid as follows:

From Age 60 to 62		**From Age 62 and Over**	
Monthly Single Life Annuity	$925.88	Monthly Single Life Annuity	$925.88
Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865	Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865
Monthly 50% Joint & Survivor Annuity	$800.89	Monthly 50% Joint & Survivor Annuity	800.89
Plus	+	*Plus*	+
Early Retirement Supplement (Social Security Bridge Benefit)	$1,083.33	Early Retirement Supplement (Social Security Bridge Benefit)	$0.00
Total monthly pension benefit payable during Bob's lifetime	$1,884.22	Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45	Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

Bob's supplemental benefit is paid only during his lifetime (as a temporary single life annuity), and no further benefits will be payable after his death. If Bob had elected to take his pension payment as a lump sum, however, then the Supplement would also be distributed as a lump sum.

Deferred Vested Pension

If you have completed five or more years of Credited Service with the Company, you may receive a deferred vested pension when you terminate your employment with the Company. You may start your pension benefit as of the later of the first day of the month in which you reach age 65 and the month after you apply for your deferred vested pension. If you have reached age 55 when you terminate employment, you may start your benefit before the first day of the month in which you reach age 65. However, the pension benefit you would be eligible to receive would be reduced by 5/9 of 1% for each full month commencement of your pension benefit precedes you reaching age 65. You also have the option of taking an immediate lump sum cashout regardless of your age at termination.

Death Benefits

Surviving Spouse Benefit

Your surviving spouse is entitled to a "Surviving Spouse Benefit" if you die as an active or terminated employee after having completed at least five years of Credited Service. This benefit would begin on the date you would have attained your early retirement age, if you die before that age, or on the first day of the month following your death if you had reached your early retirement age and then died, and as though you had elected a 50% joint and survivor annuity.

Death After Reaching Your Normal Retirement Date, But Before Retirement or Termination

Your spouse will receive a benefit equal to the monthly survivor pension benefit that would have been payable as though you had retired on the first day of the month immediately prior to your death and the benefit were payable as a 50% joint and survivor annuity. Your spouse will begin receiving the benefit on the first of the month following your death.

Death After Commencement of Benefits

If you die after your pension benefit commences, a death benefit will be paid according to your selected form of payment.

Death Prior to Normal Retirement Date

If you die while an active employee but before your normal retirement date, other than the surviving spouse benefit, no death benefits are payable from the Plan unless you have made contributions to the Plan. In such a case, the death benefit would be equal to your contributions plus interest.

Minimum and Maximum Benefits From the Plan

Minimum Benefits

The minimum benefit payable will be:

- The benefit to which you would have been entitled as in effect for Plan years prior to January 1, 1989; or

- If you were covered under any Predecessor Plan, the amount of your accrued monthly pension benefit under such Predecessor Plan as of the applicable effective date of the consolidation or merger of such Predecessor Plan.

Maximum Benefits

There are certain Internal Revenue Code limits that affect the benefits payable to highly-paid employees, as defined by the IRS. If you are affected, you will be notified.

Payment Options

When you start receiving benefits, in accordance with Plan procedures, you have the following payment forms available to you:

Annuity Payment Forms

The type of annuity you elect, your age, and, if applicable, your beneficiary's age are all taken into account in calculating your pension benefit. The following annuity options are available to you:

- **Single Life Annuity**—If you are single, the single life annuity option is the standard form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it in the form of a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may elect this option with your spouse's consent.

- **50% Annuity**—If you are married, the 50% joint and survivor annuity option, with your spouse as the beneficiary, is the standard form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form. Under this option, you receive reduced monthly payments for your lifetime. If your spouse lives longer than you do, after your death, your spouse receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **50% Pop-Up Annuity**—If you are married, you may elect the 50% pop-up annuity option, with your spouse as the contingent annuitant. If your spouse dies after the date you started receiving your benefit and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. If you die before your spouse, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments

equal to 66-2/3% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

Five or Ten Year Certain and Life Annuity Option

Under this method, you will receive a benefit for the rest of your life. However, your pension payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you make this choice, the benefit paid to you during your life will be reduced to provide the guaranteed benefit you select.

Lump-Sum Payment

You may elect to receive the actuarial equivalent of your accrued benefit in a single lump-sum payment. No further benefits would be payable from the Plan. If the actuarial equivalent of your accrued benefit is $5,000 or less when you leave the Company, the Company automatically pays you a single lump-sum payment after you leave. If you are married at the time you want your benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less.

If you are married, you can choose (1) the single life annuity, (2) the 50% pop-up annuity with your spouse as beneficiary or (3) the five or ten year certain form of distribution, only if your spouse consents. If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Example of Payment Options:

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65), your spouse were also age 65 and with an accrued benefit of $1,200.00 per month.

Payment Options	Your Monthly Benefit for Life	Your Beneficiary's Monthly Benefit After Your Death
Lump Sum Payment *($171,281)**	$0.00	$0.00
Single Life Annuity	$1,200.00	$0.00
50% Joint & Survivor Annuity	$1,050.00	$525.00
66-2/3% Joint & Survivor Annuity	$999.60	$666.40
100% Joint & Survivor Annuity	$900.00	$900.00

Five-Year Certain & Life Annuity	$1,182.00	$1,182.00 **
Ten-Year Certain & Life Annuity	$1,140.00	$1,140.00 **
50% Joint & Survivor Pop-Up Annuity	$1,032.00 ***	$516.00

* The exact lump sum amount varies with the age at payment and the interest rate in effect for the current year.

** Beneficiary payments under the Certain & Life Annuity options are payable only through the end of the guarantee period.

*** Under the Pop-Up Annuity option if your spouse dies first, then the monthly payment to you increases to $1,200.00.

Automatic Cash-Out Provision

If, at the time of payout, the actuarial equivalent of your accrued benefit does not exceed $5,000, the Plan Administrator will automatically pay you the actuarial equivalent of your accrued benefit in one lump sum.

Your Other Benefits At Retirement

Retiree Medical Benefits

A separate Company-funded account has been established to pay for certain medical benefits of certain retirees and their dependents. Effective July 1, 1994, the Company ceased making contribution to this account. Benefits will continue to be funded through this account until the account balance has been exhausted. At that time, the provision of retiree medical benefits will be made outside the Plan. To be eligible for retiree medical benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company. Any medical coverage to which a retiree and his dependents have become entitled ends upon the death of the retiree.

Retiree Life Insurance

To be eligible for retiree life insurance benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company.

Please note that the retiree medical and life insurance benefits described above are governed by the formal plan documents for those benefit programs, and this SPD does not alter or expand upon those formal plan documents. The Company reserves the right to amend, modify or terminate the programs in whole or in part.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of Credited Service, you will not be entitled to a pension benefit and your pension benefit is forfeited.

- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.

- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights.

- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;

- References to the Plan provision(s) on which the denial is based;

- A description of any additional material or information that is necessary to complete the claim; and

- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to MySource the Bay State Gas Pension Source, which handles the day-to-day administration of the Plan at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under Internal Revenue Code rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the Bay State Gas Company Savings Plan for Operating Employees, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity or term certain forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant. If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under the Plan under the same option if you work less than 40 hours (or 8 days) per month. If you work 40 or more hours (or 8 or more days) per month, your benefit payments will be suspended until you work less than 40 hours (or 8 days) per month. When you subsequently leave the Company or retire, your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours (or 8 or more days) per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours (or 8 days) per month on and after reaching normal retirement age, you may begin receiving your pension benefit from the Plan.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnisheed, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to your former spouse or dependent. This is known as a "Qualified Domestic Relations Order." As soon as you are aware of any court proceedings that may affect your pension benefit, contact the Bay State Gas Pension Source at **1-877-587-5866**.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you, and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including

insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;

- Logging on to the Internet at www.dol.gov/dol/ebsa; or

- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

The Company reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

The Company may make modifications or amendments to the Plan if appropriate or necessary. Amendments will normally not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100% vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits under the Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000.**

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Administrative Information

Plan Sponsor

The Plan Sponsor is Bay State Gas Company

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attn: NiSource Inc. and Affiliates Retirement Plan
Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for the Company is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 010. The official Plan name is the Pension Plan for Operating Employees of Bay State Gas Company.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan administrator or the trustee.

Collective Bargaining Agreement

Your benefits under the Plan are subject to the following collective bargaining agreement:

Location	Union/Local	Term of Collective Bargaining Agreement
Northampton, MA	International Brotherhood of Electrical Workers Local 486	June 19, 2004 – June 18, 2010

Bay State Gas Company Pension Plan - Salaried

Account Balance Option

Summary Plan Description (SPD)

DRAFT FOR DISCUSSION PURPOSES ONLY

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As a non-union employee of Bay State Gas Company or any affiliate that adopts the Plan for its employees (collectively, "Company"), you are automatically enrolled in the Account Balance Option of the Bay State Gas Company Pension Plan ("Plan") if you satisfy the criteria described in the Eligibility and Enrollment section.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of January 1, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion.

Introduction to the Account Balance Option

You are covered under the Account Balance Option of the Plan. As a participant, you do not make any contributions to the Account Balance Option. The Company makes an automatic contribution each year to a hypothetical account for you. Benefits are determined by your eligible pay, your years of service, and the annual interest rate. The Plan's normal retirement benefits begin at age 65, but the Plan has the flexibility to provide early retirement benefits and a number of different options for receiving benefits. The features of the Account Balance Option are:

- The Company contributes a pay credit to your account as of December 31 of each year. (The pay credit is a pre-determined percentage of your eligible pay that is based on the sum of your age and your years of service).

- Every year on December 31, an interest credit, based on the interest rate on the 30-year Treasury Securities rate for September of the prior year, is added to your account.

- You are eligible for a vested pension benefit after five years of service with the Company.

- When you leave the Company, you can defer receipt of your vested benefit or request a cash distribution either in a lump sum, rollover or as annuity payments.

- If you die, your designated beneficiary or beneficiaries will be eligible to receive your vested pension benefit.

Highlights of the Account Balance Option of the Plan

Employee Contribution	None
Company Contribution	Yes; based on the following: • Your Age • Your years of service • Your eligible pay • 30-year Treasury Securities rate, and • Social Security Taxable Wage Base.
Vesting	100% vested after 5 years of service
Eligible Pay	Base Salary and Commissions, plus your performance base related pay (*i.e.*, Annual Incentive), and "banked" vacation in the year of your termination
When Your Benefit is Paid *(Provided you are vested)*	• When you terminate employment • When you retire • In the event of your death • Age 70-1/2
Retirement Age *Distribution not contingent on reaching retirement age*	• Normal Retirement (Later of age 65 or 5th anniversary of employment) • Early Retirement (age 55 with 10 years of service)
Payment Options	• Various Monthly Annuity Options • Lump Sum • Rollover
Survivor Benefit	• Monthly Annuity Option • Lump Sum

Eligibility and Enrollment

Generally, you are eligible to participate in the Account Balance Option of the Plan if you are a regular, full-time, part-time or temporary, non-union employee excluding an intern, contractor or leased employee of the Company. Certain union employees are also eligible to participate in the Account Balance Option of the Plan.

Eligible participants are:

1. Any person employed on December 31, 2001, who was still employed on June 30, 2002 and who elected to participate in the Account Balance Option effective January 1, 2002; *

2. Any person newly hired or rehired on or after January 1, 2002;

3. Any person on long-term disability as of January 1, 2002 who returns to active employment and who elects to participate in the Account Balance Option effective upon return to employment; and

4. Certain other person who were allowed to elect to participate in the Account Balance Option pursuant to terms of the Plan.

Note: Each employee who participated in the Final Average Pay Option of the Plan had the opportunity to make a one-time irrevocable Plan choice to stay in the Final Average Pay Option or switch to the Account Balance Option ("Choice"), unless the collective bargaining agreement covering the employee did not provide for Choice. If no Choice was made, the employee remained in the Final Average Pay Option under the Plan.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts once you have completed 12 months of employment with the Company. If you are a part-time employee, your participation starts on your first day at work with the Company.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

Vesting Service

The vesting of (your non-forfeitable right to) your pension benefit is based on your years of service as an employee of the Company or any affiliate from your date of employment through the date of your termination of employment for any reason. You are 100% vested in your pension benefit after completing five years of service with the Company and/or an affiliated company.

Your vesting service is measured from the date you join the Company or any affiliate to the date you terminate, die or retire. *Special rules may apply if you experience a break-in-service, become disabled or if you were previously a leased employee of the Company or an affiliate.*

Point Service

Point Service is the period of your employment used to determine the amount of pay credits that are added to your Account Balance Option Account. Your Point Service is based on your years of service as an employee of the Company or any affiliate from the first day of the month that includes your date of employment through the last day of the year in which your termination of employment, for any reason, occurs.

Eligible Pay

Your eligible pay, which determines your pay credits, (refer to the "Pay Credits" section for further information) includes your annual base pay received from the Company. It also includes the following:

- Salary reduction contributions made for you under a cafeteria plan or a 401(k) plan,
- Commissions, if you are compensated in whole or in part on a commission basis, and
- Performance based pay such as bonuses.

In addition, your eligible pay for the year in which you terminate employment with the Company and its affiliates will include any amounts attributable to "banked" vacation under the NiSource Vacation Policy, dated January 1, 2004.

Eligible pay does not include:

- Overtime,
- Amounts deferred to a nonqualified plan, and
- Other special forms of compensation, such as shift differential, call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances, and imputed income.

Break in Service

You have a break in service if you do not return to active employment within 12 months after leaving the Company. The length of broken service is used to determine whether to reinstate service earned before termination if you are later re-employed.

If the length of your break in service is more than your period of prior service or five consecutive one-year breaks in service and you were not vested, you lose credit for all your prior service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when you terminated employment, the service you earned before your termination will be added to the service you earn when you return to work. However, the Company does not count the interim period you were away as part of your service.

Break in Service and Leaves

When determining if a break in service has occurred, up to 501 hours will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be beneficial to you in preventing a break in service.

You will not have a break in service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn service for eligibility and vesting during your disability. If you become disabled, you will also continue to earn Point Service while the disability continues without regard to whether your employment has terminated. Point Service for disability shall cease to be credited as of the earliest of the date on which your disability ends, the date on which you return to employment, or the date your benefits under the Plan commences.

Transfers

From Affiliate

If you transfer from employment providing coverage under an affiliate's non-union defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will remain in the affiliate's plan.

If you transfer from employment providing coverage under an affiliate's union defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will participate in the Plan, subject to the eligibility and enrollment provisions of the Plan. You will receive credit for Point Service for the period before and after the transfer.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's non-union defined benefit plan, you will remain in the Plan.

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's union defined benefit plan, your account will be frozen as of the date of your transfer, but will continue to earn interest credits until it is distributed.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

Protected Benefit

This section applies if you had the opportunity to choose to have your retirement benefits under the Plan calculated under either the Final Average Pay Option or the Account Balance Option. If you chose the Account Balance Option, you did not lose what you had already earned under the Plan. Rather, your benefit as of December 31, 2001 under the Final Average Pay Option was converted to a lump sum opening account balance in the Account Balance Option. Your opening account balance is the present value of your accrued benefit as of that date (based on final average pay and service as of that date) that would be paid to you monthly if you elected retirement at age 60 (or immediately if you are older than age 60) and continuing for the rest of your life. However, your pension benefit under the Account Balance Option can never be less than the Plan benefit you would have earned under the Final Average Pay Option as of June 30, 2002.

Benefit Determination

Generally, at the end of each calendar year (December 31), the Company allocates two kinds of credits to your account:

- **Pay Credits**—On December 31 of each year, the Company allocates pay credits to your account based on a percentage of your eligible pay. The percentage is based on a combination of your age and Point Service. The total age and Point Service you accumulate each year, as of December 31, determine your annual pay credit percentage. For example, a participant who turns age 40 on June 1, and reaches 15 years of Point Service on September 30, will have a total of 55 as of December 31.

- **Social Security Wage Base and your Pay Credit**—The Social Security Wage Base ("SSWB") is the maximum amount of eligible pay on which you and the Company pay Social Security taxes each year. For 2004, the SSWB is $87,900. Because you do not pay Social Security taxes on eligible pay above the SSWB, you do not earn Social Security benefits on eligible pay in excess of the SSWB. As a result, Social Security as a percentage of your retirement replacement income is lower. To help compensate affected employees, the Account Balance Option provides additional credit on eligible pay over one-half the SSWB, which is $43,950 in 2004 ($87,900 divided by 2).

- **Interest Credits**—Your account grows with interest that is credited to your account each year (on December 31). Interest Credits are based on the 30-year Treasury Securities rate (published by the IRS) for September of the preceding year and are applied to your account balance based on the value of your account balance as of the last day of the prior year. For example, if your account balance on January 1, 2004 is $50,000, then on December 31, 2004, your account is credited with interest equal to the average 30-year Treasury Securities rate for September 2003. Because that

rate was 5.14 percent, your account would be credited with $2,570 ($50,000 × 5.14 percent) on December 31, 2004.

The interest credited to your account each year will vary, based on the 30-year Treasury Securities rate. If you leave the Plan mid-year, you will receive interest through the date your benefits are paid.

Your "Account Balance Account" is the sum of:

1. *Opening Account Balance* – Present value of your Accrued Benefit, if any, under the Plan as of December 31, 2001 (or later);

2. *Pay Credit* – An annual percentage of eligible pay based on age plus Point Service per the following table:

Age Plus Point Service	Percentage of Eligible Pay	Percentage of Eligible Pay Above ½ of the Social Security Taxable Wage Base in effect that year
Fewer than 45	5.0%	2.0%
45-59	6.5%	2.0%
60-74	8.0%	2.0%
75 and over	10.0%	2.0%

And

3. *Interest Credits* – The annual interest rate on 30-year Treasury Securities per IRS Notice 2002-26 for the September immediately preceding the first day of the Plan Year, but no less than 4%.

Your pay credit may potentially have two parts depending on how much you earn. First, a basic pay credit is determined based on your total eligible pay in any given calendar year. Then, an excess pay credit is determined for any eligible pay that exceeds one-half of that year's Social Security Wage Base.

The best way to understand how pay credits are determined each year is to look at some examples.

Calculating Your Basic and Excess Pay Credits

If you are 55 years old, have eligible earnings of $50,000 and have completed 20 years of Point Service at the end of 2004, your 2004 pay credit would be calculated as follows:

Basic Pay Credit

Your 2004 eligible pay	$50,000
Your basic pay credit % (55 + 20 = 75 points = 10%)	X 10%
Your basic pay credit amount on December 31, 2004	***$5,000***

Excess Pay Credit

Your 2004 eligible pay over ½ SSWB ($50,000 – $43,950)	$6,050
Your excess pay credit %	X 2%
Your excess pay credit amount on December 31, 2004	***$121***

Your total pay credit on December 31, 2004 is the sum of these two amounts: $5,121 ($5,000 + $121) for the year.

Adding It Up: Interest and Pay Credits

With the addition of both interest and pay credits each year, you can see your account balance grow. Here is an example of how your account can grow in one year, using the same assumptions from the previous example.

Adding It Up: Interest and Pay Credits

January 1 account balance	$50,000
	+
December 31 interest credit (5.14%)	$2,570
	+
December 31 basic pay credit (10%)	$5,000
	+
December 31 excess pay credit (2%)	$121
December 31 account balance	***$57,691***

Remember, how your account grows over time depends on the actual base pay increases and performance-based pay you receive and the interest credits allocated to your account.

When Your Account is Paid

You (or your beneficiary) are entitled to the actuarial equivalent of the full value of your account as soon as possible after:

- You retire at or after age 65 with 5 years of service, or at or after age 55 with 10 years of service;
- You leave the Company before retirement with at least 5 years of service; or
- You die with at least 5 years of service.

You can elect to receive the value of your account in an immediate single lump-sum payment or, if your account value is over $5,000, you may defer payment to a later date. If you defer payment to a later date, your account continues to earn interest credits until distribution.

Under the Plan, you are allowed to defer distributions until the April 1st of the year after the year in which you reach age 70-1/2. If your account is left in the Plan, the actuarial equivalent of the entire balance can be distributed to you in any month, provided you request a distribution.

If you die before receiving any pension payments, the actuarial equivalent value of your account, will be transferred to your spouse or other beneficiary you have named under the rules of the Plan.

Designation of Beneficiary

When you first join the Plan, you will need to name a beneficiary for your Account Balance Option account. Your beneficiary is the person or persons who will receive your Account Balance Option benefit if you die before receiving it. You may choose anyone as your beneficiary. However, if you are married and you want to name someone other than your spouse as your beneficiary, you must obtain your spouse's written consent. Your spouse's consent, if given, must be witnessed by a notary public or a Plan representative. A beneficiary designation form will be sent to you when you become eligible to join the Plan.

Applying for Benefits

If you are retiring, you can call Bay State Gas Pension Source at 877-587-5866 to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your payments begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Provided you have a vested benefit, the following distribution forms apply to your pension benefit when you leave the Company:

- Lump Sum Distribution
- Rollover (all or part of the payment) into the NiSource Inc. Retirement Savings Plan, an IRA, a 403(b) plan, a governmental 457 plan or another qualified plan
- Annuity Payments
- Defer receiving your vested account balance to a later date (as long as your account balance exceeds the minimum for an automatic cash-out, which is currently $5,000).

Payment Forms

When you retire or leave the Company you have the following payment forms available to you:

Lump-Sum Payment

In certain cases, you may be eligible to receive the actuarial equivalent of your Plan account balance in a single lump-sum payment. No further benefits would be payable from the Plan. If the actuarial equivalent of your account balance is $5,000 or less when you leave the Company, the Company automatically pays you a single lump-sum payment after you leave. If you are married at the time you want your benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less.

Effective March 28, 2005, if the actuarial equivalent of your pension benefit is $1,000 or less when you leave the Company, the Company automatically pays you a single lump-sum payment after you leave. If the actuarial equivalent of your pension benefit is greater than $1,000 but less than or equal to $5,000 and you do not elect to have the distribution directly rolled over to an eligible retirement plan or to receive the lump-sum payment directly, then the Plan administrator will roll over your pension benefit to an individual retirement plan designated by the Plan administrator. If you are married at the time you want your pension benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less.

Annuity Payment Forms

If you choose to receive a monthly benefit for your lifetime (also called an annuity) from the Plan (available if the value of your account is over $5,000), the value of your account is converted to an annuity. To determine your monthly benefit, your account balance is divided by an actuarial factor based on your age when benefits start. The type of annuity you elect and, if applicable, your

beneficiary's age is also taken into account in calculating your benefit amount. The following annuity options are available to you:

- **Single Life Annuity**—If you are single, the single life annuity option is the standard form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it in the form of a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end.

- **50% Annuity**—If you are married, the 50% Annuity with your spouse as the contingent annuitant, is the standard form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form. Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime.

- **50% Pop–Up Annuity** - If your beneficiary dies within 60 months after the date you started receiving your benefit and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. In that case, all benefits would stop at your death. If your beneficiary dies more than 60 months after the date you started receiving your benefit and before you die, your monthly payment will remain the same as when your beneficiary was living and all payments will stop at your death. If you are married, you may choose this distribution option (with a reduction for the value of the pop –up feature) with your spouse or with a beneficiary other than your spouse, with your spouse's consent. If you are single, you may choose this distribution option.

- **33-1/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 33-1/3% of your benefit for his or her lifetime.

- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime.

- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your beneficiary lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime.

Payments under any of these options (other than the unreduced 50% Pop-Up Annuity) will be based on the actuarial equivalent of your account balance account. If you are married, you can choose (1) the single life annuity, (2) the 33-1/3% or 50% Pop-up annuity with your spouse as beneficiary or (3) any form of distribution with a beneficiary other than your spouse, only if your spouse consents. If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Normal Retirement – Hewitt provide new amounts

If you are age 65 or older, or when you have completed 5 years of service (if later), you may retire with a normal retirement pension.

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65), with an account valued at that time of $200,000and your spouse were also age 65.

Payment Options	Your Monthly Benefit for Life	Your Spouse's Monthly Benefit for Life After Your Death
Lump Sum Payment *($200,000)*	$0.00	$0.00
Single life annuity	$1,331.27	$0.00
50% Annuity		
50% Pop-Up Annuity	$1,223.44 *	$611.72
33-1/3% Annuity	$1,258.05	$419.35
66-2/3 %Annuity	$1,191.49	$794.33
100% Annuity	$1,132.91	$1,132.91

Early Retirement

If you have completed 10 years or more of service and are age 55 or older, you may retire before your normal retirement age with an early retirement pension. However, the amount you would be eligible to receive would be based on the actuarial equivalent of your account balance account according to your age.

Deferred Vested Pension

If you have completed 5 or more years of service with the Company, you may receive a deferred vested pension when you terminate your employment with the Company. You may start your pension benefit before or at your normal retirement age. However, the amount you would be eligible to receive would be based on the actuarial equivalent of your account balance account according to your age.

Death Benefits

If you are vested in your account balance account and die before you begin receiving your pension benefit, your spouse or, if applicable, other named beneficiary will receive the actuarial equivalent of value of your account balance account.

If your beneficiary is your spouse, he or she can choose to receive your account as follows:

- A monthly benefit, payable for the life of your spouse; or
- A single lump-sum payment, paid on the first day of the month following your death, if he or she elects.

If your beneficiary is someone other than your spouse, your account will be paid out in a lump sum.

If you elect an annuity and you die after you began receiving benefit payments, your beneficiary may be entitled to your remaining benefit, depending on the form of payment you selected.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of vesting service, you will not be entitled to a pension benefit and your pension benefit is forfeited.
- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.
- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to someone other than you or your designated beneficiary to meet payments for child support, alimony or marital property rights.
- If you die before your pension benefits begin and are unmarried, your pension benefit is payable to your beneficiary, estate or trust.
- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.
- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and

- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to Bay State Gas Pension Source which handles the day-to-day administration of the Plan, at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under IRS rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant.

If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under the Plan under the same option if you work less than 40 hours (or 8 days) per month. If you work 40 or more hours (or 8 or more days) per month, your benefit payments will be suspended until you work less than 40 hours (or 8 days) per month. When you subsequently leave the Company or retire, your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you received the full value of your vested benefit or Plan account prior to the date you return to work (for example, by electing to receive a single lump-sum payment), you will re-enter the Plan as an account balance participant. A new account will be set up in your name and you will be eligible to earn annual pay credits and interest credits for the time you work after your return.

If you had not begun receiving benefits prior to your return to work, regardless of the option under which your prior benefits were calculated, you would re-enter the Plan as an account balance participant. You are eligible to earn annual pay credits and interest credits for the time you work after your return.

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours (or 8 or more days) per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours (or 8 or more days) per month on and after reaching normal retirement age, you may begin receiving your pension benefit from the Plan.

Plan Statements

Once each year, generally during the first quarter, you will receive a statement showing the value of your account—including contributions made by the Company and interest earned during the previous year. It will help you see how your account grows from year to year. You can also call the Bay State Gas Pension Source at 877-587-5866 at any time for information on the value of your account.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnisheed, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to someone else—your former spouse, for example. This is known as a "Qualified Domestic Relations Order." As soon as you are aware of any court proceedings that may affect your pension benefit, contact the Bay State Gas Pension Source at 877-587-5866. To receive a copy of the Plan's procedures that govern QDRO determinations, contact the Bay State Gas Pension Source. These procedures will be made available to you or your beneficiary free of charge.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

If the Plan Becomes "Top-Heavy"

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated account balances or benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than $130,000, and

employees who are 1-percent-owners of the Company with annual compensation of more than $150,000, 5 -percent-owners of the Company and beneficiaries of the above. You will be notified if this affects you.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If

you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;
- Logging on to the Internet at www.dol.gov/dol/ebsa; or
- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

Bay State Gas Company ("Bay State") reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

Bay State may make modifications or amendments to the Plan if appropriate or necessary. Amendments will not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100% vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to Bay State after all required

benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, Bay State would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;

- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and

- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact MySource for Human Resources at **1-888-640-3320** or contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington, D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000.**

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Administrative Information

Plan Sponsor

The Plan Sponsor is Bay State Gas Company.

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attn: NiSource Inc. and Affiliates Retirement
Plan Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for Bay State is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 008. The Account Balance Option is a cash balance plan. The official Plan name is the Bay State Gas Company Pension Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan trustee is responsible for holding the assets of the trust fund according to Bay State's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan administrator or the trustee.

Glossary of Terms

Account Balance Option. An option to earning pension benefits that expresses your pension benefit as a hypothetical account balance, similar to a savings account, making it easy to see and understand the value of your pension benefit.

Eligible pay. For purposes of determining pay credits under the Account Balance Option, eligible pay includes your annual base salary, salary reduction contributions made for you under a cafeteria or 401(k) plan, and commissions, plus your performance-related pay such as bonuses. In addition, your eligible pay for the year in which your terminate employment with the Company and its affiliates will include any amounts attributable to "banked" vacation under the NiSource Vacation Policy, dated January 1, 2004. It does not include pay such as overtime, amounts deferred to a nonqualified plan, shift differential, call-out, standby, upgrades, temporary reclassifications/promotions, relocation allowances and imputed income. Eligible pay is limited by IRS maximums.

Interest credit. An amount that is added to your account each year as of December 31 based on the 30-year Treasury Securities rate for September of the preceding year and applied to your account balance based on the value of your account as of the last day of the prior year.

Pay credit. On December 31 of each year, the Company allocates pay credits to your account equal to a percentage of your eligible pay. The percentage is based on a combination of your age and years of service with the Company and its affiliates ("Point Service"). The total age and Point Service you accumulate each year, as measured on December 31, determine your annual pay credit percentage.

30-year Treasury Securities rate. The market indicator to which the interest credit allocated to your Plan account is tied. The Treasury Securities rate is issued by the IRS.

Bay State Gas Company Pension Plan

Final Average Pay

Summary Plan Description (SPD)

DRAFT FOR DISCUSSION PURPOSES ONLY

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As a non-union employee of Bay State Gas Company or any affiliate that adopts the Plan for its employees (collectively, "Company"), you were enrolled in the Final Average Pay option of the Bay State Gas Company Pension Plan ("Plan") if you participated in the Plan on December 31, 2001, satisfied the criteria described in the Eligibility and Enrollment section and chose during June 2002 to remain in the Final Average Pay Option. However, if you are a union employee of the Company, you will not participate in the Plan unless the collective bargaining agreement that covers you provides for your participation.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of January 1, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan Document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion.

Introduction to the Final Average Pay Option

You are covered under the Final Average Pay Option of the Plan. As a participant, you do not make any contributions to the Final Average Pay Option. The Final Average Pay Option is designed to provide you with a monthly income at retirement, based on your years of Credited Service and your final average pay. The Plan also provides a monthly benefit payable to your eligible spouse in the event of your death.

Under the Final Average Pay Option, your benefits are based on certain factors at the time you retire:

- Your years of Credited Service. Your years of Credited Service are based on your total period of participation in the Plan.
- Your final average pay. Your FAP is the average of your Pensionable Wages during the 36 consecutive months of highest earnings in your last 120 months of employment (subject to Internal Revenue Code maximums);
- Your Covered Compensation for Social Security purposes; and
- Your age at the time you retire.

Pension Benefits

The following pension benefits are available under the Plan:

- A normal retirement pension if you retire on or after your normal retirement age (age 65).
- An early retirement pension if you retire on or after reaching age 55 and before reaching age 65 with at least ten years of Credited Service, or after reaching age 60 with at least five years of Credited Service.
- A deferred vested benefit based on your final average pay and Credited Service up to your termination date if you leave employment with at least five years of Credited Service, but before you are eligible for a normal or early retirement pension. Your years of Credited Service for this purpose are based on your period of employment with the Company and any affiliates.

Your pension benefit is payable for your lifetime. In addition, your eligible spouse may receive a continuing benefit in the event of your death.

Highlights of the Pension Plan

Employee Contribution	None
Company Contribution	Yes; 100%
Vesting	100% vested after 5 years of Credited Service
Pensionable Wages	Total straight time wages and contributions through a salary reduction agreement to a 401(k) plan, a Section 125 cafeteria plan and a Section 132(f)(4) transportation fringe benefit plan, and banked vacation in the year of termination. Also included are 100% of sales commissions and daily or weekly overtime and supplementary incentive compensation pay up to the percentage of base pay set forth in the table included in the Pensionable Wages section of this booklet.
When Your Benefit is Paid *(provided you are vested)*	• When you terminate employment • When you retire • In the event of your death • April 1 of the year after the year in which you reach age 70-1/2
Retirement Age	• Normal Retirement (later of age 65 or 5th anniversary of participation) • Early Retirement (age 55 with ten years of Credited Service or age 60 with 5 years of Credited Service)
Payment Options	• Various Monthly Annuity Options • Lump Sum
Survivor Benefit	• Monthly Annuity Option

Eligibility and Enrollment

Generally you are considered an eligible participant in the Final Average Pay Option if (1) you are employed by the Company in an administrative, professional, supervisory, clerical or technical position, (2) you are employed by the Company's Springfield, Lawrence, Brockton, Portland, Lewiston or Portsmouth division or at its Westborough office (other than a person employed by the Company and assigned exclusively to its so-called CONSERV Division), or (3) you are covered by a collective-bargaining agreement between the Company and Engineering and Architectural Association Local 112 of the International Federation of Professional Technical Engineers, AFL-CIO-CLC (Decertified on August 27, 1993) or by a collective bargaining agreement between the Company's Brockton Division and the Utility Workers of America, AFL-CIO Local Union No. 273, Clerical/Technical Unit.

When Your Participation Begins

If you were participating in the Plan on December 31, 2001 and continued to be actively employed on June 30, 2002, you had the opportunity during the election period in June 2002 to make an irrevocable decision as to which type of retirement option you wanted – the Final Pay Option or the Account Balance Option.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

Credited Service

Credited Service is used in determining your eligibility for a pension benefit as well as in calculating the amount of your benefit. A year of Credited Service for this purpose means each calendar year during which you complete at least 1,000 hours of work as a Company employee.

If you work and are paid for less than 1,000 hours in any year, you will not be credited with a year of Credited Service for that year. If you return to the Company as an eligible employee working at least 1,000 hours a year, you will again be eligible to earn a year of Credited Service under the Plan.

If you were covered under one of the predecessors to the Plan prior to January 1, 1976, your Credited Service will include your most recent period of uninterrupted actual service with the Company prior to January 1, 1976 (as determined under the predecessor plan); provided however, that this provision will not result in a benefit that is less than 50% of the benefit that you would otherwise be entitled to receive. In addition, if your total number of years of Credited Service includes a fractional year, the total will be rounded off to the nearest whole number of years, either up or down as applicable. You also earn Credited Service during any period in which you qualify for benefits under NiSource's Long-Term Disability Plan. Credited Service will not include service after December 31, 1997 for employees of Energy USA or EnergyXpress.

Vesting Service

The vesting of (your non-forfeitable right to) your pension benefit is based on your years of Credited Service. For purposes of vesting only, Credited Service will also include your service with the Company or any affiliate during which you were not eligible to participate in the Plan. You are 100% vested in your pension benefit after completing five years of Credited Service with the Company and/or an affiliate.

Your Vesting Service is measured from the date you join the Company or any affiliate to the date you terminate, die or retire. *Special rules may apply if you experience a break-in-service, become disabled or if you were previously a leased employee of the Company or an affiliate.*

Pensionable Wages

Pensionable Wages includes straight time wages, contributions through a salary reduction agreement to a 401(k) plan, a cafeteria plan under Code Section 125 or a qualified transportation fringe under Code Section 132(f)(4). It also includes banked vacation in the year of termination. In addition, Pensionable Wages includes 100% of sales commissions and daily or weekly overtime and supplementary incentive compensation payments up to the percentage of base pay indicated in the following table.

Incentive Level Number	Maximum Percentage of Base Pay Includable
3 and above (Formerly B and C, D, and F, and Grades 34 and below)	20%
2 (Formerly Band A, and Grades 35-39)	25%
1 (Formerly Band E, and Grade 40+)	35%

Covered Compensation

Your Covered Compensation is the average (without indexing) of the taxable wage base in effect for each calendar year during the 35-year period ending with the last day of the calendar year in which you attain or will attain Social Security retirement age.

Break in Service

You have a Break in Service if you do not complete more than 500 hours of service in a Plan Year. The length of broken Credited Service is used to determine whether to reinstate Credited Service earned before termination if you are later re-employed.

If you were not vested when you had a Break in Service, you keep all your Credited Service if the Break ends before the period of broken service equals five years, or the Credited Service you earned before your termination (if less than five years). If the length of your Break in Service is more than your period of prior Credited Service or five consecutive one-year breaks in Service and you were not vested, you lose credit for all your prior Credited Service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when your Break in Service began, the Credited Service you earned before the Break will be added to the Credited Service you earn when the Break ends. However, the Company does not count the interim period you were away as part of your Credited Service.

Break in Service and Leaves

When determining if a Break in Service has occurred, up to 501 hours will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be beneficial to you in preventing a Break in Service.

You will not have a Break in Service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn Credited Service for eligibility, and vesting and determining the amount of your benefit during your disability. Credited Service shall cease to be credited as of the earliest of the date on which your disability ends; the date on which you return to employment, or the date your benefits under the Plan commences.

Transfers

From Affiliate

If you transfer from employment providing coverage under an affiliate's non-union defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will remain in the affiliate's plan.

If you transfer from employment providing coverage under an affiliate's union defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will participate in the Account Balance Option of the Plan, subject to the eligibility and enrollment provisions of the Plan. You will receive credit for Point Service for the period before and after the transfer.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's non-union defined benefit plan, you will remain in the Plan.

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's union defined benefit plan, your accrued benefit under the Plan will be frozen as of the date of your transfer.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

When Your Pension Benefit Is Paid

When your pension benefit is paid, you are entitled to your accrued benefit as soon as possible after:

- You retire at or after the later of age 65 or your fifth anniversary of Plan participation, at or after age 55 with 10 years of Credited Service, or at or after age 60 with five years of Credited Service
- You leave the Company before retirement with at least 5 years of Credited Service; or
- When you die with at least 5 years of Credited Service.

You can receive the value of your vested pension benefit when you retire. Normal retirement is the later of age 65 or your fifth anniversary of Plan participation. If you meet the ten year Credited Service requirement, you could retire as early as age 55 and receive a reduced benefit. If you meet the five year Credited Service requirement, you could retire as early as age 60 and receive a reduced benefit.

Under the Plan, your vested pension benefits are payable to you upon retirement. You are vested in your benefit after you complete five years of Credited Service. Credited Service is measured for this purpose from your first day of work at the Company or an affiliate to the date your employment ends. Special rules may apply if you leave the Company and later return, if you are a leased employee, if you or on LTD or on military leave. For more information regarding these special rules, see the Plan Administrator.

Designation of Beneficiary

If you are married and if you die before commencing your pension benefit, a death benefit will be paid to your surviving spouse, if any. If you die after commencing your pension benefit, your spouse, if you are married at the time your benefit commences, is your beneficiary unless, with spousal consent, you have elected Certain and Life Annuity with a different beneficiary.

If you are single and you die before commencing your pension benefit, there is no death benefit. If you die after commencing your pension benefit, your beneficiary may receive a pension benefit if you have selected an optional form of payment.

Applying for Benefits

If you are eligible to begin receiving benefits, you can call the Bay State Gas Pension Source at 877-587-5866 to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your benefits begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible upon your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Upon retirement, you can decide to:

- Receive your full accrued benefit if you retire at normal retirement age.
- Receive a reduced accrued benefit if you retire early, based on your age and Credited Service at the time you retire.
- Defer your accrued benefit to a later date if you retire early. Your benefit is calculated as of the date you actually retire, with any reduction based on the date you later elect to begin receiving benefits. If you wait until normal retirement date, the reduction does not apply.

Normal Retirement

Your monthly pension benefit will be:

1. 1.4% of your final average pay (subject to limits established in the formal Plan documents) not in excess of Covered Compensation plus 1.875% of final average pay in excess of Covered Compensation, all multiplied by years of Credited Service (not in excess of 25 years); plus

2. 0.5% of your final average pay multiplied by years of Credited Service in excess of 25 years; and reduced by

3. any benefit to which you are entitled from any other plan maintained by a former employee and which is attributable to service with the Company, for which credit is given under the Plan.

Example 1: Normal Retirement Benefit, if Single

Bob has worked for the Company for 35 years with a final average pay of $45,000 which is less than Covered Compensation. He retires at age 65. His monthly single life annuity retirement benefit is calculated as follows:

1.4% x $45,000 x 25	$15,750.00
0.5% x $45,000 x 10 (service over 25)	$ 2,250.00
Annual Benefit	$18,000.00
Single Life Monthly Annuity	$ 1,500.00

Minus (Any benefit to which Bob may be entitled under any Predecessor Plan)

This is the monthly amount payable to Bob if he is single. If he is married, the benefit will be paid under a 50% Joint and Survivor Annuity as shown in Example 2.

Normal Retirement Benefit, if married

If you are married and have not chosen (with a notarized written spousal consent) another method of receiving your pension, your surviving spouse will automatically receive, after your death, a benefit equal to one-half of your pension under the 50% Joint and Survivor Annuity. Your spouse will receive this benefit for the rest of his or her life. Because this arrangement will usually result in benefit payments being paid over a longer period of time than under the single life annuity, the amount of your benefit is reduced by a factor, which takes into account your spouse's age and your age at the time of your retirement.

Example 2: 50% Joint and Survivor Annuity

Using the example above, if Bob is married, and he and his wife are age 65 and he has elected the 50% Joint and Survivor Annuity, his benefit would be calculated as follows:

Single Life Monthly Annuity *(as previously calculated in Example 1)*	$1,500.00
Multiply by reduction factor for a 50% Joint and Survivor Annuity Option as determined by actuarial calculations	.875
Total Monthly Benefit payable during Bob's lifetime	$1,312.50
Total Monthly Benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$ 656.25

If Bob and his wife elected another form of payment, as described in the "Forms of Payment" section, the monthly benefit amount would change.

Brockton Division Union Employee

If you are an employee who is employed in the Company's Brockton Division and who is a member of the Utility Workers' Union of America AFL-CIO, Local Union No. 273 Clerical/Technical Unit, your pension benefit will be computed under a different formula. For an explanation of your pension benefits see the Summary Plan Description for the Brockton Clerical/Technical Division.

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Early Retirement

If you have at least 10 years of Credited Service, you can retire on or after age 55 and receive an enhanced early pension benefit. The enhanced early pension benefit is also available if you have at least five years of Credited Service and retire on or after age 60.

Your early retirement benefit is based on the same formula used for normal retirement, reduced by a reduction factor that varies by your age and years of Credited Service at the time of retirement:

- If you have completed at least 25 years of Credited Service and you retire after age 55 but prior to 62, the reduction factor is 3/10 of 1% for each full calendar month between the date such benefit commences and the date you reach age 62.

- If you have completed at least 25 years of Credited Service and retire after reaching age 62, there is no reduction factor.

- If you have completed less than 25 years of Credited Service, the reduction factor is 3/10 of 1% for each full calendar month between the date your benefit is to commence and your normal retirement date.

Example 3: Early Retirement with 25 years of Credited Service

Suppose Bob is married and wants to retire at age 62 after 25 years of Credited Service and wants pension benefits to start as soon as he retires.

Normal Retirement Benefit at Age 65

The amount of pension benefit at normal retirement = $1,771.88 Monthly

Reduction for Early Retirement

Bob has 25 years of Credited Service and is retiring at age 62. Therefore, there is no reduction.

Total Benefit Payable at Early Retirement

Bob's benefit payable at age 62 is the same as would be payable at 65, or $1,771.88.

Example 4: Early Retirement with 24 Years of Credited Service

Suppose Bob, in the above example, had only 24 years of Credited Service at the time he elected to retire at age 62. (Although the normal retirement benefit amount would be lower with less service, for the purpose of this illustration we will assume that the benefit is the same as above.)

Normal Retirement Benefit at Age 65

The amount of pension benefit at normal retirement = $1,771.88

Reduction for Early Retirement

Reduced 3/10 of 1% for each month retirement is before age 65 (35 months in this case).

3/10 of 1% x 35 months = 10.5%

Thus an early retirement reduction factor of 89.5% (1 – 10.5%) will be applied to the normal retirement benefit.

Total Benefit Payable At Early Retirement

The normal retirement benefit at age 65 less the reduction for early retirement equals the total Single Life Annuity payable to Bob at early retirement.

$1,771.88 x 89.5% = $1,585.83 Monthly

The total monthly annuity benefit payable to Bob at early retirement would be $1,585.83.

If Bob is married, his spouse is age 60 and he has not waived the 50% Joint and Survivor Annuity, his early retirement benefit would be paid as follows:

Single Life Annuity Starting at Age 62	$1,585.83
Multiply by reduction factor for a 50% Joint and Survivor Annuity Option as determined by actuarial calculations	.865
Total Monthly Benefit payable during Bob's lifetime	$1,371.74
Total Monthly Benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$ 685.87

Early Retirement Supplement

The Plan provides eligible employees a supplemental retirement income benefit when they elect to take early retirement. This supplemental benefit, also referred to as the "Social Security Bridge" or "Early Retirement Supplement"," is intended to provide additional retirement income if you retire on or after age 60 but before age 62.

If you retire on or after age 60 but before age 62, your pension will be increased, but only until you reach age 62 or die, whichever occurs sooner, by an amount equal to 2% of your final average pay not in excess of Covered Compensation multiplied by your years of Credited Service (but not more than 25 years). Your temporary supplement may not exceed the Primary Social Security Benefit to which you would be entitled at age 62.

Supplemental Benefit with 24 Years of Credited Service

Lets assume Bob is retiring at age 60 with 24 years of Credited Service. His annual final average pay is $45,000. Bob's supplemental benefit from age 60 to age 62 would be the following:

Supplemental Benefit at Early Retirement

2% x $45,000 x 24 yrs = $21,600.00 Annually

$21,600.00 / 12 = $1,800.00 Monthly

Maximum Applied to Supplement

Assume the Primary Social Security Benefit provides an annual benefit of $13,000.00 for Bob payable at age 62. *This is the maximum amount he can receive as an early retirement supplement between ages 60 and 62.*

$13,000.00 / 12 = $1,083.33 Monthly

The total monthly supplemental benefit that Bob would receive would be $1,083.33.

Total Monthly Benefit Payable at Age 60 Early Retirement with 24 years of Credited Service

The monthly retirement benefits (r*educed early retirement benefits plus the supplement*) paid to Bob as a single life annuity would be:

From Age 60 to 62		**From Age 62 and Over**	
Reduced Early Retirement Benefit	$1,458.26	Reduced Early Retirement Benefit	$1,458.26
Plus	+	*Plus*	+
Early Retirement Supplement	$1,083.33	Early Retirement Supplement	$0
Total Monthly Single Life Annuity Benefit	$2,541.59	Total Monthly Single Life Annuity Benefit	$1,458.26

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

If Bob is married, his spouse is age 58, and he has elected the 50% Joint and Survivor Annuity, his early retirement benefit would be paid as follows:

From Age 60 to 62		**From Age 62 and Over**	
Monthly Single Life Annuity Starting at Age 60	$1,458.26	Monthly Single Life Annuity Starting at Age 60	$1,458.26
Multiply by reduction factor for a 50% Joint and Survivor Annuity Option as determined by actuarial calculations	.865	Multiply by reduction factor for a 50% Joint and Survivor Annuity Option as determined by actuarial calculations	.865
Monthly 50% Joint & Survivor Annuity at Age 60	$1,261.39	Monthly 50% Joint & Survivor Annuity at Age 60	$1,261.39
Plus	+	*Plus*	+

Early Retirement Supplement (Social Security Bridge Benefit)	$1,083.33	Early Retirement Supplement (Social Security Bridge Benefit)	$0.00
Total Monthly Annuity Benefit payable during Bob's lifetime	$2,344.72	Total Monthly Annuity Benefit payable during Bob's lifetime	$1,261.39
Total Monthly Annuity Benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$ 630.70	Total Monthly Annuity Benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$ 630.70

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

Bob's early retirement supplement is paid as a temporary single life annuity, and no further supplemental benefits will be payable after his death. If Bob had elected to take his pension payment as a lump sum, however, then the Supplement would also be distributed as a lump sum.

Deferred Vested Pension

You will be eligible for a deferred vested pension beginning at age 65 if you terminate employment with the Company for any reason before you are eligible for early retirement but after you have completed at least five years of Credited Service. You may begin your deferred vested pension in a reduced amount as early as the first of the month following your last day worked. The reduction is equal to 5/9 of 1% for each full calendar month from the date the benefit is to commence to your normal retirement date.

Death Benefits

If you die prior to your termination of employment, your beneficiary will receive a death benefit equal to the accrued benefit derived from any employee contributions you made to the Plan or any Predecessor Plan that have not previously been distributed.

If you are married and vested in your pension benefit, and are actively employed by the Company at the time of your death or you have terminated employment with the Company and died before you start receiving your pension benefit, your spouse will receive a monthly benefit for his or her lifetime equal to the amount he or she would have received if you had terminated on your date of death, survived to your early retirement date, and elected to receive your pension benefit as a 50% Joint and Survivor Annuity. The death benefit will begin on the first day of the month following:

(1) the date of your death if you were eligible for normal retirement when you died,

(2) the date of your death if you were eligible for early retirement when you died (or can be delayed by your spouse to a later date), or

(3) the date you would have reached early retirement age if you were not eligible for early retirement when you died.

The calculation assumes you were terminated or retired immediately preceding your death and elected to receive a 50% Joint and Survivor Annuity. If you are single, no survivor benefit is payable.

If you die after you begin receiving benefit payments under the Plan, your beneficiary could be entitled to a portion of the benefit you were receiving, depending on the optional form of payment you originally elected.

Minimum and Maximum Benefits from the Plan

Minimum Benefits

The minimum benefit payable will be:

- The benefit to which the employee would have been entitled as in effect for Plan Years prior to January 1, 1989; or

- In the case of an employee who was covered under any Predecessor Plan, the amount of his accrued monthly pension under such Predecessor Plan as of the applicable effective date of the consolidation or merger of such Predecessor Plan.

Maximum Benefits

There are certain Internal Revenue Code limits that affect the benefits payable to highly-paid employees, as defined by the Code. If you are affected, you will be notified.

Payment Options

When you start receiving benefits, in accordance with Plan procedures, you can take your accrued benefit as an annuity that pays you a monthly income or in a lump sum.

Payment Forms

You will normally receive your pension benefit in the form of a monthly benefit (also called an annuity). The type of annuity you elect and if applicable your beneficiary's age, is also taken into account in calculating your monthly benefit amount. The following annuity options and a lump sum option are available to you:

- **Single Life Annuity –** If you are single, the single life annuity option is the standard form of payment. This means that unless you elect to receive your benefit in a different form of

payment, you will receive it in the form of a single life annuity. With a single life annuity you receive monthly payments for your lifetime. When you die, payments end.

- **50% Joint & Survivor Annuity** – If you are married, the 50% Joint and Survivor annuity, with your spouse as the beneficiary, is the standard form of payment. This means that you will receive your benefit in this form of payment unless you elect a different form. Under this option, you receive reduced monthly payments for your lifetime. If your spouse lives longer than you do, after your death, your spouse receives monthly payments equal to 50% of your benefit for his or her lifetime. You may not choose this option with a beneficiary other than your spouse.

- **66-2/3% Joint & Survivor Annuity** – Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. You may not choose this option with a beneficiary other than your spouse.

- **100% Joint & Survivor Annuity** – Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. You may not choose this option with a beneficiary other than your spouse.

- **Five or Ten Year Certain and Life Annuity** – Under this option, you will receive a benefit for the rest of your life. However, your pension payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you make this choice, the benefit paid to you during your life will be reduced to provide the guaranteed benefit you select.

- **Joint and Survivor Pop-Up Option** – Under this option, if you are married, you will receive a reduced monthly pension during your lifetime. If you die before your spouse, your spouse will receive a monthly pension for the remainder of his or her lifetime equal to 1/2 of the reduced amount you were receiving. If your spouse dies before you, you will receive, beginning on the first day of the month coincident with or next following the death of your spouse, a monthly benefit equal to the benefit you would have received in the form of a single life annuity without any reduction.

- **Lump Sum** – Under this method, you receive the actuarial equivalent of your benefit in a single lump sum.

If you are married, you can choose the Single Life option, a lump sum payment, the joint and survivor pop-up option or a Certain and Life option, only if your spouse consents. If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Example of Payment Options:

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65) and your spouse were also age 65 with an accrued benefit of $1,331.27 per month.

Payment Options	Your Monthly Benefit for Life	Your Spouse's Monthly Benefit for Life After Your Death
Single life annuity	$1,331.27	$0.00
50% Annuity	$1,164.86	$582.43
66-2/3% Annuity	$1,108.95	$739.34
100% Annuity	$998.45	$998.45

Cash Out Provision

If, at the time of distribution, the actuarial equivalent of your pension benefit does not exceed $5,000, the Plan Administrator has the right to automatically pay you the actuarial equivalent of your pension benefit in one lump sum.

Your Other Benefits at Retirement

Retiree Medical Benefits

A separate Company-funded account has been established to pay for certain medical benefits of certain retirees and their dependents. Effective July 1, 1994, the Company ceased making contribution to this account. Benefits will continue to be funded through this account until the account balance has been exhausted. At that time, the provision of retiree medical benefits will be made from accounts outside the Plan. To be eligible you must be eligible to retire under the Plan and actually retire from the Company. Any medical coverage to which a retiree and his dependents have become entitled ends upon the death of the retiree.

Please note that the retiree medical benefits described above are governed by the formal plan documents for this program, and this SPD does not alter or expand upon that formal plan documents. The Company reserves the right to amend, modify or terminate the program in whole or in part.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of vesting Credited Service, you will not be entitled to a pension benefit and your pension benefit is forfeited.

- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.

- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to your former spouse or dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights.

- If you die before your pension benefits begin and are unmarried, no pension benefit is payable to your beneficiary, estate or trust.

- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;

- References to the Plan provision(s) on which the denial is based;

- A description of any additional material or information that is necessary to complete the claim; and

- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the Bay State Gas Pension Source, which handles the day-to-day administration of the Plan at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370
Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later

than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under Internal Revenue Code rules, if the present value of your pension benefit is $5,000 or less, and paid to you in a lump-sum payment, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant. If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under, the Plan under the same option if you work less than 40 hours per month. If you work 40 or more hours per month, your benefit payments will be suspended until you subsequently leave the Company or work less than 40 hours per month. At that time your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching normal retirement age, you may begin receiving your pension benefit from the Plan.

Plan Statements

Once each year, generally during the first quarter, you will receive a statement showing the value of your pension benefit. It will help you see how your pension benefit grows from year to year. You can also call the Bay State Gas Pension Source at **1-877-587-5866** at any time for information on the value of your pension benefit.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnisheed, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to your former spouse or dependent. This is known as a "Qualified Domestic Relations Order." As soon as you are aware of any court proceedings that may affect your pension benefit, contact the Bay State Gas Pension Source at **1-877-587-5866.**

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

If the Plan Becomes "Top-Heavy"

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated account balances or benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than $130,000, and highly paid employees who are 1 percent-owners of the Company with annual compensation of more than $150,000, 5 percent-owners of the Company and beneficiaries of the above. You will be notified if this affects you.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**; Logging on to the Internet at www.dol.gov/dol/ebsa; or

- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

The Company reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

The Company may make modifications or amendments to the Plan if appropriate or necessary. Amendments will normally not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100% vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;

- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000.**

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Administrative Information

Plan Sponsor

The Plan Sponsor is Bay State Gas Company

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.

Attn: NiSource Inc. and Affiliates Retirement Plan
Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for the Company is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 008. The official Plan name is the Bay State Gas Company Pension Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan administrator or the trustee.

Pension Plan for Operating Employees of Bay State Gas Company

Springfield Clerical/Technical Division

United Steelworkers of America AFL-CIO-CLC, Local Union # 12026

Plan # 010

Agreement Period: 05/15/04 - 05/15/13

Summary Plan Description (SPD)

DRAFT FOR DISCUSSION PURPOSES

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As a union employee covered by a collective bargaining agreement between Bay State Gas Company (the "Company") and the United Steelworkers of America, AFL-CIO-CLC Local #12026 Clerical/Technical Unit or by any other collective bargaining agreement that provides for participation in the Plan for its employees, you are automatically enrolled in the Pension Plan for Operating Employees of Bay State Gas Company ("Plan") if you satisfy the criteria described in the Eligibility and Enrollment section.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of May 15, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion, subject to the terms of the applicable collective bargaining agreements.

Introduction to the Pension Plan

As a participant, you do not make any contributions to the Plan. The Plan is designed to provide you with a monthly income at retirement, based on your years of Credited Service and your final average pay. The Plan also provides a monthly benefit payable to your eligible spouse in the event of your death.

Under the Plan, your benefits are based on certain factors at the time you retire:

- Your years of Credited Service. Your years of Credited Service are based on your total period of participation in the Plan.

- Your final average pay. Your final average pay is 1/36 of your base pay during the highest 36 months in your last 120 months of employment (subject to a Plan cap); and

- Your age at the time you retire.

Benefit Options

The following pension benefit options are available under the Plan:

- A normal retirement pension if you retire on or after your normal retirement age (age 65).

- An early retirement pension if you retire on or after age 55 with at least ten years of Credited Service.

- A deferred vested benefit based on your final average pay and Credited Service up to your termination date if you leave employment with at least five years of Credited Service, but before you are eligible for a normal or early retirement pension.

Your pension benefit is payable for your lifetime. In addition, your eligible spouse may receive a continuing benefit in the event of your death.

Highlights of the Plan

Employee Contribution	None
Company Contribution	Yes; 100%
Vesting	100% vested after 5 years of Credited Service
Eligible Pay	Base pay
When Your Benefit is Paid *(provided you are vested)*	• When you terminate employment • When you reach early or normal retirement age • In the event of your death • April 1 of the year after the year in which your reach age 70-1/2
Retirement Age	• Normal Retirement (age 65) • Early Retirement (age 55 with 10 years of Credited Service)
Payment Options	• Various Monthly Annuity Options • Lump Sum • Rollover
Survivor Benefit	• Monthly Annuity Option

Eligibility and Enrollment

Generally, you are eligible to participate in the Plan if you are an employee of Bay State Gas Company – Springfield Division and you are covered by a collective bargaining agreement between the Company and the United Steelworkers of America AFL-CIO-CLC on behalf of Local Union No. 12026 Clerical/Technical Unit covering the period from May 15, 2004 to May 15, 2013, or you meet the eligibility requirements under any other collective bargaining agreement that provides for participation in the Plan for its employees.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts when your employment begins. You are automatically enrolled in the Plan.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your collective bargaining agreement no longer provides for participation in the Plan;
- The Plan ends; or
- You die.

Hour of Service

For Plan purposes, such as eligibility for early retirement and Credited Service for the purpose of calculating your retirement benefit from the Plan, an hour of service means each hour for which you are directly or indirectly paid, or entitled to payment, by the Company as a Plan participant.

Credited Service

Credited Service is used in determining your eligibility for a pension benefit, including vesting, as well as in calculating the amount of your benefit.

Your Credited Service is the number of calendar years in which you have completed at least 1,000 hours of service. An hour of service is each hour for which you are paid for working or are entitled to be paid for work (*e.g.*, vacation and sick days). You also earn Credited Service during any period in which you qualify for benefits under NiSource's Long-Term Disability Plan. Earlier periods of employment with the Company may also count as Credited Service.

If you transfer from an affiliate company, the amount of your pension will be based upon the aggregate period of Credited Service only during your employment with the Company and each affiliate that has adopted the Plan.

For purposes of vesting only, Credited Service will also include your service with the Company and any affiliate during which you were not eligible to participate in the Plan.

Eligible Pay

Your eligible pay is your base pay. All daily and weekly overtime, bonuses, supplementary incentive compensation payments, retirement benefits and other forms of non-recurring compensation are not included.

Final Average Pay

Your final average pay is 1/36 of your base pay paid or accrued to you during the highest 36 consecutive months in your last 120 months of employment. The Plan limits final average pay to a maximum of $55,000.

Break in Service

You have a break in service if you do not return to active employment within 12 months after leaving the Company. The length of broken service is used to determine whether to reinstate service earned before termination if you are later re-employed.

If you were not vested when you terminated employment, you keep all the service if you return to work before the period of broken service equals five years, or if you return to work before the period of broken service is greater than the service you earned before your termination. If the length of your break in service is more than the greater of your period of prior service or five years and you were not vested, you lose credit for all your prior service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when you terminated employment, the service you earned before your termination will be added to the service you earn when you return to work. However the Company does not count the interim period you were away as part of your service.

Break in Service and Leaves

Note that any year in which you receive credit for 500 or more hours is not considered a break in service. When determining if a break in service has occurred, up to 501 hours of service will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours of service will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be more beneficial to you in preventing a break in service.

You will not have a break in service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn Credited Service while the disability continues. Credited Service shall cease to be credited as of the earliest of the date on which your disability ends; the date on which you return to employment, or the date your benefits under the Plan commences.

Transfers

From Affiliate

If you transfer from employment providing coverage under an affiliate's defined benefit plan on or after July 1, 2002 to employment providing coverage under the Plan, you will participate in the Plan, subject to the eligibility and enrollment provisions of the Plan.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's defined benefit plan, your accrued benefit under the Plan will be frozen as of the date of your transfer.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

When Your Pension Benefit is Paid

You (or your beneficiary) are entitled to your accrued benefit as soon as possible after:

- You retire at or after age 65, or at or after age 55 with 10 years of Credited Service;
- You leave the Company before retirement with at least five years of Credited Service; or
- You die.

If your accrued benefit is over $5,000 and you terminate employment after completing five or more years of service, you may defer payment to a later date.

Applying for Benefits

If you are retiring, you can call the Bay State Gas Pension Source at **1-877-587-5866** to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your payments begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Upon retirement you can decide to:

- Receive your full accrued benefit if you retire at normal retirement age.
- Receive a reduced accrued benefit, if you retire early, based on your age at the time you retire.
- Defer your benefit to a later date, if you retire early. Your benefit is calculated as of the date you actually retire with any reduction based on the date you later elect to begin receiving benefits. If you wait until your normal retirement date, the reduction does not apply.

Normal Retirement

When you retire at age 65 or later, your monthly pension benefit will be based on your Credited Service (up to a maximum of 45 years) and your final average pay (up to a Plan cap). Your monthly pension benefit will be equal to:

1. 1.25% of your final average pay multiplied by your years of Credited Service not in excess of 45 such years; reduced by

2. any benefit to which you are entitled (or would be entitled if you were to make an election to receive such benefit at time of commencement of your benefit under the Plan) from any other plan maintained by the Company, and which is attributable to service with the Company, for which Credited Service is given under the Plan.

The annual final average pay cap is $55,000.

Example 1: Normal Retirement Benefit, if Single

Bob has worked for the Company for 35 years with a final average pay of $45,000.00. He retires at age 65. His pension benefit is calculated as follows:

1.25% x $45,000.00 x 35	=	$19,687.50 per year
$19,687.50 / 12	=	$ 1,640.63 per month

(Minus any benefit to which Bob may be entitled under any Predecessor Plan)

This is the pension benefit payable to Bob if he is single. If he is married, his pension benefit will be paid under a Joint and Survivor Annuity as shown in Example 2.

Example 2: Normal Retirement Benefit, if Married

If you are married and have not chosen (with a notarized, written spousal consent) another method of receiving your pension benefit, your surviving spouse will automatically receive, after your death, a benefit equal to one-half of your pension benefit as a 50% joint and survivor annuity. Your spouse will receive this benefit for the rest of his or her life. Because this arrangement will usually result in benefit payments being paid over a longer period of time than under a single life annuity, the amount of your pension benefit is reduced by a factor, which takes into account your spouse's age and your age at the time of your retirement.

Using the example above, if Bob is married and he and his spouse are age 65, his pension benefit paid as a 50% joint and survivor annuity is calculated as follows:

Single life annuity *(as previously calculated in Example 1)*	$1,640.63
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.875
Total monthly pension benefit payable during Bob's lifetime	$1,435.55
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$717.78

If Bob elected another form of payment, with his wife's consent, as described in the "Forms of Payment" section, the monthly benefit amount would change.

Early Retirement

You may retire as early as the first of the month following or coinciding with the date you reach age 55, if you have completed at least 10 years of Credited Service (early retirement). You may choose to start receiving your pension benefit in any month on or after your early retirement or elect to start receiving your pension benefit at age 65, based upon your final average pay and Credited Service at the time of early retirement.

Your early retirement benefit is based on the same formula used for normal retirement, reduced by a factor that varies by your age and years of Credited Service:

- If you have completed at least 25 years of Credited Service and you retire after age 55 but prior to 60, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 60.

- If you have completed at least 25 years of Credited Service and retire after reaching age 60, there is no reduction factor.

- If you have completed less than 25 years of Credited Service, the reduction factor is 3/10 of 1% for each full calendar month between the date your pension benefit commences and the date you would reach age 65.

Example 3: Early Retirement with 25 years of Credited Service

Suppose Bob wants to retire at age 60 after 25 years of Credited Service and wants pension benefits to start as soon as he retires. Assume his final average pay is $45,000.00:

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 25 = $14,062.50 per year

Reduction for Early Retirement

Because Bob has 25 years of Credited Service and is retiring at age 60, there is no reduction. Therefore, Bob's monthly pension benefit payable at age 60 is the same as would be payable at 65, or $14,062.50 per year ($1,171.88 per month).

Example 4: Early Retirement with 24 Years of Credited Service

Suppose Bob, in the above example, had only 24 years of Credited Service at the time he elected to retire at age 60.

Bob's Normal Retirement Benefit at Age 65

The amount of monthly pension benefit beginning at age 65 equals 1.25% of his final average pay multiplied by his years of Credited Service.

1.25% x $45,000.00 x 24 = $13,500.00 per year

Reduction for Early Retirement

Bob's normal retirement benefit is reduced 3/10 of 1% for each full month that he retires before he reaches age 65 (59 months in this case).

3/10 of 1% x 59 months = 17.7%

Thus an early retirement reduction factor of 82.3% (1 – 17.7%) will be applied to the Normal Retirement Benefit calculated above.

Bob's normal retirement benefit at age 65 less the reduction for early retirement equals the monthly single life annuity payable to Bob at early retirement.

$13,500.00 x 82.3% = $11,110.50 per year

$11,110.50 / 12 = $ 925.88 per month

The monthly pension annuity benefit payable to Bob at early retirement would be $925.88.

If Bob is married and his spouse is age 58, his early retirement benefit would be paid as follows:

Single life annuity starting at age 60	$925.88
Multiply by reduction factor for a 50% joint and survivor annuity as determined by actuarial calculations	.865
Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her	$400.45

lifetime	

Supplemental Benefit

The Plan provides eligible employees a supplemental benefit when they elect to take early retirement. This supplemental benefit, also referred to as the "Social Security Bridge" or "Early Retirement Supplement", is intended to provide additional retirement income if you retire on or after age 60 but before age 62.

If you retire on or after age 60 but before age 62, your monthly pension benefit will be increased, but only until you reach age 62 or die, whichever occurs sooner, by an amount equal to 2% of your final average pay (subject to Internal Revenue Code limits) multiplied by your years of Credited Service (but not more than 25 years). However, your temporary supplement may not exceed the Primary Social Security Benefit to which you would be entitled at age 62.

Supplemental Benefit with 24 Years of Credited Service

Lets assume Bob retires at age 60 with 24 years of Credited Service. His final average pay is $45,000.00. Bob's supplemental benefit from age 60 to age 62 would be the lesser of the following:

(1) Supplemental Benefit at Early Retirement

2% x $45,000.00 x 24 yrs = $21,600.00 per year ($1,800.00 per month)

(2) Maximum Supplement – The Primary Social Security Benefit would provide an annual benefit of $13,000.00 for Bob payable at age 62 ($1,083.33 per month). *This is the maximum amount Bob could receive as an early retirement supplemental benefit between ages 60 and 62.*

Thus the total monthly supplemental benefit that Bob would receive would be $1,083.33.

Total Monthly Benefit Payable at Age 60 Early Retirement with 24 years of Service

If Bob is single, the monthly pension benefit (r*educed early retirement benefits plus the supplemental benefit*) paid to him as a single life annuity would be:

From Age 60 to 62		**From Age 62 and Over**	
Reduced early retirement benefit	$925.88	Reduced early retirement benefit	$925.88
Plus	+	*Plus*	+
Supplement Benefit	$1,083.33	Supplement benefit	$0.00
Total monthly pension benefit	**$2,009.21**	**Total monthly pension benefit**	**$925.88**

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental

benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

If Bob is married and his spouse is age 58 and he elects a 50% joint & survivor annuity, then his early retirement benefit would be paid as follows:

From Age 60 to 62		**From Age 62 and Over**	
Monthly Single Life Annuity	$925.88	Monthly Single Life Annuity	$925.88
Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865	Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865
Monthly 50% Joint & Survivor Annuity	$800.89	Monthly 50% Joint & Survivor Annuity	800.89
Plus	+	*Plus*	+
Early Retirement Supplement (Social Security Bridge Benefit)	$1,083.33	Early Retirement Supplement (Social Security Bridge Benefit)	$0.00
Total monthly pension benefit payable during Bob's lifetime	$1,884.22	Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45	Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

Bob's supplemental benefit is paid only during his lifetime (as a temporary single life annuity), and no further benefits will be payable after his death. If Bob had elected to take his pension payment as a lump sum, however, then the Supplement would also be distributed as a lump sum.

Deferred Vested Pension

If you have completed five or more years of Credited Service with the Company, you may receive a deferred vested pension when you terminate your employment with the Company. You may start your pension benefit as of the later of the first day of the month in which you reach age 65 and the month after you apply for your deferred vested pension. If you have reached age 55 when you terminate employment, you may start your benefit before the first day of the month in which you reach age 65. However, the pension benefit you would be eligible to receive would be reduced by

5/9 of 1% for each full month commencement of your pension benefit precedes you reaching age 65. You also have the option of taking an immediate lump sum cashout regardless of your age at termination.

Death Benefits

Surviving Spouse Benefit

Your surviving spouse is entitled to a "Surviving Spouse Benefit" if you die as an active or terminated employee after having completed at least five years of Credited Service. This benefit would begin on the date you would have attained your early retirement age, if you die before that age, or on the first day of the month following your death if you had reached your early retirement age and then died, and as though you had elected a 50% joint and survivor annuity.

Death After Reaching Your Normal Retirement Date, But Before Retirement or Termination

Your spouse will receive a benefit equal to the monthly survivor pension benefit that would have been payable as though you had retired on the first day of the month immediately prior to your death and the benefit were payable as a 50% joint and survivor annuity. Your spouse will begin receiving the benefit on the first of the month following your death.

Death After Commencement of Benefits

If you die after your pension benefit commences, a death benefit will be paid according to your selected form of payment.

Death Prior to Normal Retirement Date

If you die while an active employee but before your normal retirement date, other than the surviving spouse benefit, no death benefits are payable from the Plan unless you have made contributions to the Plan. In such a case, the death benefit would be equal to your contributions plus interest.

Minimum and Maximum Benefits From the Plan

Minimum Benefits

The minimum benefit payable will be:

- The benefit to which you would have been entitled as in effect for Plan years prior to January 1, 1989; or

- If you were covered under any Predecessor Plan, the amount of your accrued monthly pension benefit under such Predecessor Plan as of the applicable effective date of the consolidation or merger of such Predecessor Plan.

Maximum Benefits

There are certain Internal Revenue Code limits that affect the benefits payable to highly-paid employees, as defined by the IRS. If you are affected, you will be notified.

Payment Options

When you start receiving benefits, in accordance with Plan procedures, you have the following payment forms available to you:

Annuity Payment Forms

The type of annuity you elect, your age, and, if applicable, your beneficiary's age are all taken into account in calculating your pension benefit. The following annuity options are available to you:

- **Single Life Annuity**—If you are single, the single life annuity option is the standard form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it in the form of a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end. If you are married, you may elect this option with your spouse's consent.

- **50% Annuity**—If you are married, the 50% joint and survivor annuity option, with your spouse as the beneficiary, is the standard form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form. Under this option, you receive reduced monthly payments for your lifetime. If your spouse lives longer than you do, after your death, your spouse receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **50% Pop-Up Annuity**—If you are married, you may elect the 50% pop-up annuity option, with your spouse as the contingent annuitant. If your spouse dies after the date you started receiving your benefit and before you die, your monthly payment is increased to the amount you would have received under the single life annuity option. If you die before your spouse, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **66-2/3% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **100% Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments

equal to the benefit you were receiving for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

Five or Ten Year Certain and Life Annuity Option

Under this method, you will receive a benefit for the rest of your life. However, your pension payments are guaranteed for a minimum of either five or ten years (whichever you select). If you die within five (or ten) years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five (or ten) year period. If you make this choice, the benefit paid to you during your life will be reduced to provide the guaranteed benefit you select.

Lump-Sum Payment

You may elect to receive the actuarial equivalent of your accrued benefit in a single lump-sum payment. No further benefits would be payable from the Plan. If the actuarial equivalent of your accrued benefit is $5,000 or less when you leave the Company, the Company automatically pays you a single lump-sum payment after you leave. If you are married at the time you want your benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less.

If you are married, you can choose (1) the single life annuity, (2) the 50% pop-up annuity with your spouse as beneficiary or (3) the five or ten year certain form of distribution, only if your spouse consents. If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Example of Payment Options:

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65), your spouse were also age 65 and with an accrued benefit of $1,200.00 per month.

Payment Options	Your Monthly Benefit for Life	Your Beneficiary's Monthly Benefit After Your Death
Lump Sum Payment *($171,281)**	$0.00	$0.00
Single Life Annuity	$1,200.00	$0.00
50% Joint & Survivor Annuity	$1,050.00	$525.00
66-2/3% Joint & Survivor Annuity	$999.60	$666.40
100% Joint & Survivor Annuity	$900.00	$900.00
Five-Year Certain & Life Annuity	$1,182.00	$1,182.00 **
Ten-Year Certain & Life Annuity	$1,140.00	$1,140.00 **
50% Joint & Survivor Pop-Up Annuity	$1,032.00 ***	$516.00

* The exact lump sum amount varies with the age at payment and the interest rate in effect for the current year.

** Beneficiary payments under the Certain & Life Annuity options are payable only through the end of the guarantee period.

*** Under the Pop-Up Annuity option if your spouse dies first, then the monthly payment to you increases to $1,200.00.

Automatic Cash-Out Provision

If, at the time of payout, the actuarial equivalent of your accrued benefit does not exceed $5,000, the Plan administrator will automatically pay you the actuarial equivalent of your accrued benefit in one lump sum.

Your Other Benefits At Retirement

Retiree Medical Benefits

A separate Company-funded account has been established to pay for certain medical benefits of certain retirees and their dependents. Effective July 1, 1994, the Company ceased making contribution to this account. Benefits will continue to be funded through this account until the account balance has been exhausted. At that time, the provision of retiree medical benefits will be made outside the Plan. To be eligible for retiree medical benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company. For retiree medical coverage you must also have been a full-time regular employee before September 1, 1990, and have been age 45 or above before January 1, 1992. Any medical coverage to which a retiree and his dependents have become entitled ends upon the death of the retiree.

Retiree Life Insurance

When you retire, you life insurance will continue in the amount of $5,000 at no cost to you. To be eligible for retiree life insurance benefits, you must (1) be eligible to retire under the Plan and (2) actually retire from the Company.

Please note that the retiree medical and life insurance benefits described above are governed by the formal plan documents for those benefit programs, and this SPD does not alter or expand upon those formal plan documents. The Company reserves the right to amend, modify or terminate the programs in whole or in part.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of Credited Service, you will not be entitled to a pension benefit and your pension benefit is forfeited.

- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.

- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights.

- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;

- References to the Plan provision(s) on which the denial is based;

- A description of any additional material or information that is necessary to complete the claim; and

- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the Bay State Gas Pension Source, which handles the day-to-day administration of the Plan at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under Internal Revenue Code rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20% of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the Bay State Gas Company Savings Plan for Operating Employees, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity or term certain forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant. If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under the Plan under the same option if you work less than 40 hours (or 8 days) per month. If you work 40 or more hours (or 8 or more days) per month, your benefit payments will be suspended until you work less than 40 hours (or 8 days) per month. When you subsequently leave the Company or retire, your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours (or 8 or more days) per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours (or 8 days) per month on and after reaching normal retirement age, you may begin receiving your pension benefit from the Plan.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnisheed, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to your former spouse or dependent. This is known as a "Qualified Domestic Relations Order." As soon as you are aware of any court proceedings that may affect your pension benefit, contact the Bay State Gas Pension Source at **1-877-587-5866**.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you, and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and

copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;

- Logging on to the Internet at www.dol.gov/dol/ebsa; or

- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

The Company reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

The Company may make modifications or amendments to the Plan if appropriate or necessary. Amendments will normally not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100% vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to the Company after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, the Company would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits under the Plan are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;

- Benefits that are not vested because you have not worked long enough for the Company;

- Benefits for which you have not met all of the requirements at the time the Plan terminates;

- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and

- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division, 1200 K Street NW, Suite 930, Washington D.C. 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000.**

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Administrative Information

Plan Sponsor

The Plan Sponsor is Bay State Gas Company.

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attn: NiSource Inc. and Affiliates Retirement Plan
Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for the Company is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 010. The official Plan name is the Pension Plan for Operating Employees of Bay State Gas Company.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410

Legal process may also be served on the Plan administrator or the trustee.

Collective Bargaining Agreement

Your benefits under the Plan are subject to the following collective bargaining agreement:

Location	Union/Local	Term of Collective Bargaining Agreement
Springfield, MA	United Steelworkers of America, AFL-CIO-CLC Local #12026 Clerical/Technical Unit 2025 Roosevelt Ave. Springfield, MA 01102-2025	May 15, 2004 - May 15, 2013

Pension Plan for Operating Employees of Bay State Gas Company

Final Average Pay

Springfield Union

Local 12026

Plan #010

Agreement Period:
05/15/04-05/15/13

DRAFT DOCUMENT FOR DISCUSSION PURPOSES ONLY

Summary Plan Description (SPD)

Hewitt comments

5/25/2005

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As a union employee covered by a collective bargaining agreement between Bay State Gas Company and the United Steelworkers of America, AFL-CIO-CLC Local #12026 or any affiliate that adopts the Plan for its employees (collectively, "Company"), you are automatically enrolled in the Pension Plan for Operating Employees of Bay State Gas Company ("Plan") if you satisfy the criteria described in the Eligibility and Enrollment section.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of May 15, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion.

Introduction to the Pension Plan

The Pension Plan is designed to provide you with a monthly income at retirement, based on your years of credited service and your average annual earnings. The Plan's normal retirement benefits begin at age 65, but it has the flexibility to provide early retirement benefits. The plan also provides a monthly benefit payable to your eligible spouse in the event of your death. As a participant, you do not make any contributions to the Pension Plan. The Company makes an automatic contribution each year on your behalf.

Under the Pension Plan, your benefits are based on certain factors at the time you retire:

- Your years of credited service. Your years of service begin on the first day of employment.
- Your Average Annual Earnings. Your Average Annual Earnings is the average of your actual base earnings during the 36 consecutive months of highest earnings in your last 120 months of employment (subject to IRS and Plan specific maximums); and
- Your age at the time you retire.

Benefit Options

The following pension benefit options are available from the Plan:

- A normal retirement pension if you retire on or after your normal retirement age (age 65)
- An early retirement pension if you retire on or after age 55 with at least ten years of service.
- A deferred vested benefit based on your pay and service up to your termination date if you leave employment with at least five years of Credited Service but before you are eligible for a normal or early retirement pension.

Your pension benefit is payable for your lifetime. In addition, your eligible spouse may receive a continuing benefit in the event of your death.

Highlights of the Pension Plan

Employee Contribution	None
Company Contribution	Yes; 100%
Vesting	100% vested after 5 years of service
Eligible Earnings	Base pay
When Your Benefit is Paid *(provided you are vested)*	• When you terminate employment • When you retire • In the event of your death • Age 70 ½
Retirement Age	• Normal Retirement (Later of age 65 or 5th anniversary of participation) • Early Retirement (age 55 with ten years of service)
Payment Options	• Various Monthly Annuity Options • Lump Sum • Rollover • Defer payment
Survivor Benefit	• Monthly Annuity Option

Eligibility and Enrollment

Generally, you are eligible to participate in the Pension Plan for Operating Employees of Bay State Gas Company (which is the employee benefit plan described in this summary plan description, or "SPD") if you are an employee of Bay State Gas Company – Springfield Division (or one of the Company's subsidiaries that participates in the Plan) employed at the Company's Springfield , MA location and you are covered by a collective bargaining agreement between the Company and the United Steelworkers of America AFL-CIO-CLC on behalf of Local Union #12026.

When Your Participation Begins

If you meet the eligibility requirements, your participation starts in the first 12- month period in which you complete an hour of employment. You are automatically enrolled in the Plan.

When Your Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- Your employer terminates its participation in the Plan;
- The Plan ends; or
- You die.

Year of Service

For Plan purposes, such as eligibility for vesting and early retirement and credited service for the purpose of calculating your retirement benefit from the Plan, a year of service means each calendar year during which you complete at least 1,000 hours of work.

If you complete less than 1,000 hours in any year, you will not be credited with a year of service for that year. If you return to the Company as an eligible employee working at least 1,000 hours a year, you will again be eligible to earn a year of service under the Plan. Your total years of service will reflect all periods of eligible employment with the Company.

Vesting Service

The vesting of (your non-forfeitable right to) your pension benefit is based on your years of service as an employee of the Company or any affiliate from your date of employment through the date of your termination of employment for any reason. You are 100% vested in your pension benefit after completing five years of service with the Company and/or an affiliated company.

Your vesting service is measured from the date you join the Company or any affiliate to the date you terminate, die or retire. *Special rules may apply if you experience a break-in-service, become disabled or if you were previously a leased employee of the Company or an affiliate.*

Eligible Pay and Average Annual Earnings

Your eligible pay is your base pay. All daily and weekly overtime, bonuses, supplementary incentive compensation payments, retirement benefits and other forms of non-recurring compensation are not included.

Your Average Annual Earnings are calculated using your base pay during the 36 consecutive months with the Company that gives you the highest average earnings out of the last 120 months.

The maximum average annual earnings as of May 15, 2004 is $65,000. This limit is scheduled to increase to $70,000 as of May 15, 2008 and $75,000 as of May 15, 2012.

Break in Service

You have a break in service if you do not return to active employment within 12 months after leaving the Company. The length of broken service is used to determine whether to reinstate service earned before termination if you are later re-employed.

If you were not vested when you terminated employment, you keep all the service if you return to work before the period of broken service equals five years, or if you return to work before the period of broken service is greater than the service you earned before your termination.

If the length of your break in service is more than the greater of your period of prior service or five years and you were not vested, you lose credit for all your prior service. If you are later re-employed, the Company will treat you as a new participant under the Plan.

If you were vested when you terminated employment, the service you earned before your termination will be added to the service you earn when you return to work. However the Company does not count the interim period you were away as part of your service.

Break in Service and Leaves

Note that any year in which you receive credit for 500 or more hours is not considered a break in service. When determining if a break in service has occurred, up to 501 hours will be credited if you are absent from work due to pregnancy, birth of a child, placement of an adopted child or caring for a child immediately after such birth or placement. The 501 hours will be credited in the year in which the absence from work begins or in the immediate following year, whichever would be more beneficial to you in preventing a break in service.

You will not have a break in service if you are on an approved leave of absence pursuant to the Family and Medical Leave Act or if you are absent from employment due to service in the uniformed services, and if you return to work at the end of your authorized leave of absence.

If you qualify for benefits under the long-term disability plan sponsored by NiSource, you continue to earn Service during your disability.

Service shall cease to be credited as of the earliest of the date on which your disability ends; the date on which you return to employment, or the date your benefits under the Plan commence.

Transfers

From Union Plan

If you were a participant in the Pension Plan for Operating Employees of Bay State Gas Company (the Union Plan) under the provisions pertaining to Springfield union and you transferred to employment providing coverage under the Bay State Gas Company Pension Plan ("the Salaried Plan") after 6/30/2002, you would be covered under the Account Balance formula. Your participation in the Salaried Plan will commence on the date of your transfer provided you meet eligibility requirements of the Salaried Plan. Your benefit in the Union Plan would be frozen as of the transfer date.

The period of employment before your transfer is included in determining your benefit under the Salaried Plan. However, if you transfer from the Union Plan to the Salaried Plan and back to the Union Plan within a 1-year period, you will be treated as never having left the Union Plan.

To Union Plan

If you transfer to an employment classification that no longer provides coverage under the Salaried Plan, and provides coverage under the Union Plan, your Salaried Plan benefit will be frozen as of the date of your transfer. If you were covered under the Account Balance Formula, you will no longer have pay credits added to your account, but you will continue to earn interest credits on the balance of your account until it is fully distributed. However, if you transfer from the Salaried Plan to the Union Plan and back to the Salaried Plan within a 1-year period, you will be treated as never having left the Salaried Plan.

From Affiliate

If you transfer from employment providing coverage under an affiliate's non-union defined benefit plan on or after July 1, 2002 to employment providing coverage under the Union Plan, your benefit

in the non-union plan will be frozen as of the transfer date, and you will begin accruing a separate benefit under the Union Plan.

If you transfer from employment providing coverage under an affiliate's union defined benefit plan on or after July 1, 2002 to employment providing coverage under the Union Plan, you will participate in the Plan, subject to the eligibility and enrollment provisions of the Plan. Your benefit under the affiliate's union plan will be frozen as of the transfer date and you will begin accruing a separate benefit under the Bay State Gas Union Plan.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

To Affiliate

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's non-union defined benefit plan, your benefit under the Plan will be frozen as of the transfer date and you will begin accruing a separate benefit under the affiliate's non-union plan..

If you transfer from employment providing coverage under the Plan on or after July 1, 2002 to employment providing coverage under an affiliate's union defined benefit plan, your benefit under the Plan will be frozen as of the transfer date and you will begin accruing a separate benefit under the affiliate's union plan.

Transfers prior to July 1, 2002 will be handled according to applicable Plan provisions.

Credited Service

Generally, you earn one full year of credited service for each calendar year in which you are credited with at least 1,000 hours of work. For periods prior to January 1, 1976, the terms of the Predecessor Plan will determine the amount of your credited service, subject to certain limitations. As of June 18, 2000, you may not be credited with more than 45 years of service.

Defined Benefit

The Plan is a defined benefit pension plan, meaning that your monthly benefit at retirement is calculated on the basis of a formula. Bay State Gas Company contributes such amounts as are necessary to fund that benefit.

How Your Benefit is Determined

Amount of Pension Benefit At Normal Retirement (Age 65 or Later)

When you retire at age 65 or later, your annual pension will be based on your credited service to retirement date and your average annual earnings. Your annual benefit under the Single Life Annuity option will be equal to:

1. 1.25% of your average annual earnings (subject to limits established in the formal Plan documents and described below) multiplied by your years of credited service up to 45 years; reduced by

2. any benefit to which employee is entitled (or would be entitled were he to make an election to receive such benefit at time of commencement of his benefit under the Plan) from any other plan maintained by the Company, and which is attributable to service with the Company, for which service is given under the Plan.

The maximum average annual earnings is $65,000 as of May 15, 2004. This limit is scheduled to increase to $70,000 as of May 15, 2008 and $75,000 as of May 15, 2012.

Example 1: Normal Retirement Benefit, if Single

Bob has worked for the Company for 35 years with an Average Annual Earnings of $45,000. He retires at age 65. His Single Life Annuity Benefit was calculated as follows:

1.25% x $45,000 x 35 = $19,687.50 Annually

$19,687.50 / 12 = $ 1,640.63 Total Monthly Benefit Payable at Normal Retirement

Minus (Any benefit to which may be entitled under any Predecessor Plan if the prior plan coverage includes a portion of the 35 years)

This is the monthly amount payable to Bob if he is single. If he is married, the benefit will be paid under a Joint and Survivor Annuity as shown in Example 2.

Example 2: Normal Retirement Benefit, if Married

If you are married and have not chosen (with a notarized written spousal consent) another method of receiving your pension, your surviving spouse will automatically receive, after your death, a benefit equal to one-half of your pension under the 50% Joint and Survivor Annuity option. Your spouse will receive this benefit for the rest of his or her life. Because this arrangement will usually result in benefit payments being paid over a longer period of time than under the Single Life Annuity Option, the amount of your benefit is reduced by a factor, which takes into account your spouse's age and your age at the time of your retirement.

Joint and Survivor Annuity Option

Using the example above, if Bob is married, and he and his wife are age 65 and he has elected the 50% Joint and Survivor Annuity, his benefit would be calculated as follows:

Single Life Monthly Annuity *(as previously calculated in Example 1)*	$1,640.63
Multiply by reduction factor for a 50% Joint and Survivor Annuity Option as determined by actuarial calculations	0.875
Total Monthly Benefit payable during Bob's lifetime	$1,435.55
Total Monthly Benefit payable to Bob's spouse (in the event of his death) for the remainder of her life	$717.78

If Bob and his wife elected another form of payment, as described in the "Forms of Payment" section, the monthly benefit amount would change.

Amount of Pension Benefits at Early Retirement

You may retire as early as the first of the month following or coinciding with the date you reach age 55 if you have 10 years of credited service. You may choose to start receiving your pension immediately upon the first of the month following or coinciding with early retirement, or you may elect to retire early and defer pension payments to the first of any month up to the month that you obtain age 65 (based upon your final average annual earnings and credited service at the time of early retirement).

Basic Plan Benefit At Early Retirement

Your early retirement benefit is based on the same formula used for normal retirement, reduced by a reduction factor that varies by your age and years of service at the time of retirement:

- If you have completed at least 25 years of credited service and you retire after age 55 but prior to 60. The reduction factor is 3/10 of 1% for each full calendar month between the date such benefit is commenced and the first of the month following the date you reach age 60.

- If you have completed at least 25 years of credited service and retire after reaching age 60 there is no reduction factor.

- If you have completed less than 25 years of credited service the reduction factor is 3/10 of 1% for each full calendar month between the date such benefit is to commence and your normal retirement date.

Example 3: Early Retirement with 25 years of Credited Service

Suppose Bob wanted to retire at age 60 after 25 years of credited service and wanted pension benefits to start as soon as he retired (59 months early). Assume his final average annual earnings is $41,000:

Normal Retirement Benefit at Age 65

The amount of pension benefit at normal retirement or 1.25% of your average annual earnings multiplied by your years of credited service.

1.25% x $45,000 x 25 /12 = $1,171.88 Monthly

Reduction for Early Retirement

Bob has 25 years of credited service and is retiring at age 60. Therefore, there is no reduction.

Total Benefit Payable at Early Retirement

Bob's benefit payable at age 60 is the same as would be payable at 65, or $1,171.88 per month.

Example 4: Early Retirement with 24 Years of Credited Service

Suppose Bob, in the above example, had only 24 years of credited service at the time he elected to retire at age 60.

Normal Retirement Benefit at Age 65

The amount of pension benefit at normal retirement or 1.25% of your average annual earnings multiplied by your years of credited service.

1.25% x $45,000 x 24 /12 = $1,125.00 Monthly

Reduction for Early Retirement

Reduced 3/10 of 1% for each month retirement is before age 65 (59 months in this case).

3/10 of 1% x 59 months = 17.7%

Thus an early retirement reduction factor of 82.3% (1 – 17.7%) will be applied to the Normal Retirement Benefit calculated above.

Total Benefit Payable At Early Retirement

The Normal Retirement Benefit at age 65 less the reduction for Early Retirement equals the total Single Life Annuity payable to Bob at Early Retirement.

$1,125.00 x 82.3% = $925.88 Monthly

The total monthly annuity benefit payable to Bob at Early Retirement would be $925.88.

If Bob is married, his spouse is age 58, and he elected the 50% Joint and Survivor Annuity, his Early Retirement Benefit would be paid as follows:

Single Life Annuity Starting at Age 60	$925.88
Multiply by reduction factor for a 50% Joint and Survivor Annuity Option as determined by actuarial calculations	.865
Total Monthly Annuity Benefit payable during Bob's lifetime	$800.89
Total Monthly Annuity Benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

Early Retirement Supplement

The Plan provides eligible employees a supplemental retirement income benefit when they elect to take early retirement. This supplemental benefit, also referred to as the "Social Security Bridge" or "Early Retirement Supplement", is intended to provide additional retirement income if you retire on or after age 60 but before age 62.

If you retire on or after age 60 but before age 62, your pension will be increased, but only until you reach age 62 or die, whichever occurs sooner, by an amount equal to 2% of your average annual earnings multiplied by your years of service (but not more than 25 years). Your temporary supplement may not exceed the estimated Primary Social Security Benefit to which you would be entitled at age 62.

Supplemental Benefit with 24 Years of Credited Service

Lets assume Bob retires at age 60 with 24 years of Credited Service. His final average pay is $45,000.00. Bob's supplemental benefit from age 60 to age 62 would be the lesser of the following:

(1) Supplemental Benefit at Early Retirement

2% x $45,000.00 x 24 yrs = $21,600.00 per year ($1,800.00 per month)

(2) Maximum Supplement – The Primary Social Security Benefit would provide an annual benefit of $13,000.00 for Bob payable at age 62 ($1,083.33 per month). *This is the maximum amount Bob could receive as an early retirement supplemental benefit between ages 60 and 62.*

Thus the total monthly supplemental benefit that Bob would receive would be $1,083.33.

Total Monthly Benefit Payable at Age 60 Early Retirement with 24 years of Service

If Bob is single, the monthly pension benefit (r*educed early retirement benefits plus the supplemental benefit*) paid to him as a single life annuity would be:

From Age 60 to 62		**From Age 62 and Over**	
Reduced early retirement benefit	$925.88	Reduced early retirement benefit	$925.88
Plus	+	*Plus*	+
Supplement Benefit	$1,083.33	Supplement benefit	$0.00
Total monthly pension benefit	**$2,009.21**	**Total monthly pension benefit**	**$925.88**

From ages 60 to 62, Bob will receive the reduced early retirement benefit plus the supplemental

benefit from the Plan. Beginning at age 62, he will receive only the reduced early retirement benefit from the Plan.

If Bob is married and his spouse is age 58 and he elects a 50% joint & survivor annuity, then his early retirement benefit would be paid as follows:

From Age 60 to 62		**From Age 62 and Over**	
Monthly Single Life Annuity	$925.88	Monthly Single Life Annuity	$925.88
Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865	Multiply by reduction factor for a 50% Joint and Survivor Annuity as determined by actuarial calculations	.865
Monthly 50% Joint & Survivor Annuity	$800.89	Monthly 50% Joint & Survivor Annuity	800.89
Plus	+	*Plus*	+
Early Retirement Supplement (Social Security Bridge Benefit)	$1,083.33	Early Retirement Supplement (Social Security Bridge Benefit)	$0.00
Total monthly pension benefit payable during Bob's lifetime	$1,884.22	Total monthly pension benefit payable during Bob's lifetime	$800.89
Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45	Total monthly pension benefit payable to Bob's spouse (in the event of his death) for the remainder of her lifetime	$400.45

From ages 60 to 62, Bob and his spouse will receive the Reduced Early Retirement Benefit plus the Supplemental Benefits from the Plan. Beginning at age 62, they will receive only the Reduced Early Retirement Benefit from the Plan.

Note that Bob's Early Retirement Supplement is paid as a temporary Single Life Annuity regardless of which annuity form of payment Bob elects. If Bob dies before age 62, the Supplement will immediately stop.

If Bob had elected to take his pension payment as a lump sum, however, then the Supplement will also be distributed as a lump sum.

Minimum and Maximum Benefits From the Plan

Minimum Benefits

The minimum benefit payable will be:

- The benefit to which the employee would have been entitled as in effect for Plan Years prior to January 1, 1989; or

- In the case of an employee who was covered under any Predecessor Plan, the amount of his accrued monthly pension under such Predecessor Plan as of the applicable effective date of the consolidation or merger of such Predecessor Plan.

Maximum Benefits

There are certain Internal Revenue Code limits that affect the benefits payable to highly-paid employees, as defined by the IRS. If you are affected, you will be notified.

When Your Benefit is Paid

You may begin receiving your pension benefits as soon as possible after:

- You retire;
- You leave the Company before retirement with at least 5 years of service; or
- You die

You can elect to receive your benefit immediately, or you may defer payment to a later date.

If the present value of your accrued benefit is $5,000 or less and you have five or more years of service when you leave the Company, your benefit will automatically be paid to you as a lump-sum soon after you leave.

Applying for Benefits

If you are retiring, you can call the Bay State Gas Pension Source at **1-877-587-5866** to request a pension benefit commencement kit.

You should request the kit 30 to 90 days before you want your pension benefit to begin. In the kit, you will find further information regarding your pension benefit and payment options. In addition, all the appropriate forms are included along with instructions on what you need to do to commence your pension benefit. You may change your payment option at any time before payments actually begin. However, once your payments begin, you may not change the form of payment you have elected.

If you leave the Company before retirement age and have a vested benefit, a notice will automatically be sent to you as soon as administratively possible after your termination. The notice will provide information regarding your pension benefit and the payment options available to you.

Provided you have a vested benefit, the following distribution forms apply to your pension benefit when you leave the Company:

- Lump Sum Distribution
- Rollover (all or part of the payment) into the NiSource Inc. Retirement Savings Plan, an IRA, a 403(b) plan, a governmental 457 plan or another qualified plan
- Annuity Payments
- Defer receiving your vested benefit to a later date (as long as the present value of your accrued benefit exceeds the minimum for an automatic cash-out, which is currently $5,000).

Payment Forms

When you retire or leave the Company you have the following payment forms available to you:

Lump-Sum Payment

In certain cases, you may be eligible to receive the actuarial equivalent of your Plan accrued benefit in a single lump-sum payment. No further benefits would be payable from the Plan. If the actuarial equivalent of your accrued benefit is $5,000 or less when you leave the Company, the Company automatically pays you a single lump-sum payment after you leave. If you are married at the time you want your benefit to be paid, your spouse must consent in writing to the lump-sum form of payment, unless the benefit is $5,000 or less.

Annuity Payment Forms

You may choose to receive a monthly benefit for your lifetime (also called an annuity) from the Plan (available if the present value of your accrued benefit is over $5,000), The type of annuity you elect, your age, and, if applicable, your beneficiary's age is taken into account in calculating your optional form of payment. The following annuity options are available to you:

- **Single Life Annuity** —If you are single, the single life annuity option is the standard form of payment. This means that, unless you elect to receive your benefit in a different form of payment, you will receive it in the form of a single life annuity. With a single life annuity, you receive monthly payments for your lifetime. When you die, payments end.

- **50% Joint & Survivor Annuity**—If you are married, the 50% Joint & Survivor Annuity with your spouse as the beneficiary, is the standard form of payment under the Plan. This means that you will receive your benefit in this form of payment unless you elect a different form. If your spouse dies first, your monthly payment will remain the same as when your spouse was living and all payments will stop at your death. If you die before your spouse, he or she receives monthly payments equal to 50% of your benefit for his or her lifetime. You may not choose this distribution option with a beneficiary other than your spouse. Thus if you are single, you may not choose this distribution option.

- **66 2/3% Joint & Survivor Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to 66-2/3% of your benefit for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **100 %Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. After your death, if your spouse lives longer than you do, he or she receives monthly payments equal to the benefit you were receiving for his or her lifetime. You may only choose this option if you are married and your spouse is your beneficiary.

- **Five-Year Certain & Life Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. However, your pension payments are guaranteed for a minimum of five years. If

you die within five years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the five year period.

- **Ten-Year Certain & Life Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. However, your pension payments are guaranteed for a minimum of ten years. If you die within ten years after you retire, your beneficiary will receive the same benefit you were receiving for the balance of the ten year period.

- **50% Joint & Survivor Pop-Up Annuity**—Under this option, you receive reduced benefits monthly for your lifetime. If your spouse dies before you, then your monthly benefit increases to the amount that you would have received under the Single Life Annuity option. If you die before your spouse, he or she receives monthly payments equal to 50% of the benefit you were receiving for his or her lifetime.

  Payments under any of these options will be based on the actuarial equivalent of your accrued benefit. If you are married, and you wish to choose (1) the Single Life Annuity, (2) a Certain & Life Annuity, or (3) the Pop-Up Annuity, then you must obtain the written consent of your spouse. If you or your beneficiary dies before an elected form of distribution begins, the election will be cancelled and the other Plan provisions will apply.

Example of Payment Options:

The following is an example that shows the amounts that would be paid to you and your spouse if you were to retire at normal retirement age (65) and your spouse were also age 65 with an accrued benefit of $1,200.00 per month.

Payment Options	Your Monthly Benefit for Life	Your Beneficiary's Monthly Benefit After Your Death
Lump Sum Payment *($171,281)**	$0.00	$0.00
Single Life Annuity	$1,200.00	$0.00
50% Joint & Survivor Annuity	$1,050.00	$525.00
66-2/3% Joint & Survivor Annuity	$999.60	$666.40
100% Joint & Survivor Annuity	$900.00	$900.00
Five-Year Certain & Life Annuity	$1,182.00	$1,182.00 **
Ten-Year Certain & Life Annuity	$1,140.00	$1,140.00 **
50% Joint & Survivor Pop-Up Annuity	$1,032.00 ***	$516.00

* The exact lump sum amount varies with the age at payment and the interest rate in effect for the current year.

** Beneficiary payments under the Certain & Life Annuity options are payable only through the end of the guarantee period.

*** Under the Pop-Up Annuity option if your spouse dies first, then the monthly payment to you increases to $1,200.00.

Automatic Cash Out Provision

If, at the time of payout, the actuarial equivalent of your retirement benefit does not exceed $5,000, the Plan Administrator has the right to automatically pay you the actuarial equivalent of your retirement benefit in one lump sum.

Deferred Vested Pension

If you have completed 5 or more years of service with the Company, you may receive a deferred vested pension when you terminate your employment with the Company. You may start your pension benefit before or at your normal retirement age. However, the amount you would be eligible to receive would be reduced by 5/9 of 1% for each month commencement precedes age 65.

Death Benefits

If You Die After Completion of Five Years of Service

Your surviving spouse is entitled to a "Surviving Spouse Benefit" if you die as an active or terminated employee after having completed at least five years of service. This benefit would be computed as though you separated from employment on the date of your death. This benefit would be payable on the date you would have attained your early retirement age and as though you had elected a 50% Joint and Survivor Annuity.

If You Die After Reaching Your Earliest Retirement Age, But Before Retirement

Your spouse will receive a benefit equal to the monthly annuity amount that would have been payable as though you had retired on the first day of the month immediately prior to your death and the benefit were payable as a 50% Joint and Survivor Annuity. Your spouse will begin receiving the benefit on the first of the month following your death. Payments to a beneficiary are calculated based on only the basic benefit to which you would have been entitled. The early retirement supplement is not payable after your death.

If You Die After Retirement

If you die after retirement, a death benefit will be paid according to your selected form of payment.

Death Benefit From Predecessor Plan

If you have not completed five years of service, no death benefits are payable from the Plan unless you have made contributions under a Predecessor Plan. In such a case, the death benefit would be equal to your contributions plus interest.

Your Other Benefits At Retirement

Retiree Medical Benefits

A separate Company-funded account has been established to pay for certain medical benefits of certain retirees and their dependents. Effective July 1, 1994, the company ceased making contributions to this account. Benefits will continue to be funded through this account until the account balance has been exhausted. At that time, the provision of retiree medical benefits will be made from accounts outside the Plan. To be eligible for retiree medical benefits, you must be eligible to retire under the Plan and actually retire from the Company. For retiree medical coverage you must also have been a full-time regular employee before September 1, 1990, and have been age 45 or above before January 1, 1992. If you leave the Company before being eligible to retire, you do not meet the eligibility condition "retire from the Company". Any medical coverage to which a retiree and his dependents have become entitled ends upon the death of the retiree.

Retiree Life Insurance

When you retire, your life insurance will continue in the amount of $5,000 at no cost to you. To be eligible for retiree life insurance benefits, you must be eligible to retire under the Plan and actually retire from the Company.

Please note that the retiree medical and life insurance benefits described above are governed by the formal plan documents for those benefit programs, and this SPD does not alter or expand upon those formal plan documents. The Company reserves the right to amend, modify or terminate the programs in whole or in part.

Situations Affecting Your Retirement Plan Benefits

The Plan is designed to provide you with income during your retirement years, but some situations could affect Plan benefits.

Several situations are summarized here:

- If your employment terminates before you have completed five years of vesting, you will not be entitled to a pension benefit and your pension benefit is forfeited.

- If you do not make the proper application for benefits, do not provide necessary information or do not provide your current address, your pension benefits could be delayed.

- If required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to someone other than you or your designated beneficiary to meet payments for child support, alimony or marital property rights.

- If you die before your pension benefits begin and are unmarried, no pension benefit is payable.

- If there is a mistake or misstatement about eligibility, participation or service, or if the amount of payment made to you or your beneficiary is incorrect, the Plan administrator will, if possible, try to correct the situation. This may be done by withholding, accelerating or adjusting payments as necessary to ensure the proper payment from the Plan is made.

- If you are a highly paid employee, the law limits the annual benefit from the retirement and tax-deferred investment plans that can be distributed to you. The amount of annual compensation, which may be considered in determining pension benefits from the Plan, is also limited by law. You will be notified if this affects you.

Claim Denial and Appeal Process

If your claim for a pension benefit is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a pension benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to the Bay State Gas Pension Source, which handles the day-to-day administration of the Plan at the following address:

Bay State Gas Pension Source
3350 Riverwood Parkway, Suite 80, 9E
Atlanta, GA 30339-3370

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Additional Information

Withholding Taxes

The Company is required by law to withhold taxes on payments from the Plan according to federal and state withholding rules in effect at the time of distribution. Under IRS rules, if you receive a lump-sum payment from the Plan, the Company is required to automatically withhold 20 % of the amount payable toward your federal tax liability for that year. You can avoid the 20% withholding by having the money directly transferred to the NiSource Inc. Retirement Savings Plan, a 403(b) plan, a governmental 457 plan, another employer's qualified plan or to an IRA. This withholding provision does not impose additional taxes. You should consult with your personal tax adviser regarding this matter.

If you elect to receive your Plan benefit under one of the annuity forms of payment available to you, this automatic 20% withholding does not apply. You will need to make your regular federal and state withholding elections before payments begin.

If You Return to Work After Retirement

If you return to work and you meet the eligibility requirements of the Plan, you will automatically become a Plan participant. If, at the time you return to work, you have already begun receiving benefit payments from the Plan, you will continue to receive payments from, and earn benefits under the Plan under the same option if you work less than 40 hours per month. If you work 40 or more hours per month, your benefit payments will be suspended until you work less than 40 hours per month. When you subsequently leave the Company or retire, your benefits will be recalculated taking into account your pension benefit earned both before and after you returned to the Company (adjusted for any benefit payments already received).

If you Continue to Work After Normal Retirement Age

If you work 40 or more hours per month on and after reaching normal retirement age, you may not begin receiving your pension benefit from the Plan. If you work fewer than 40 hours per month on and after reaching normal retirement age, you will begin receiving your pension benefit from the Plan.

Assignment of Benefits

Your pension benefit belongs to you and may not be sold, assigned, transferred, pledged or garnished, except under a Qualified Domestic Relations Order or as otherwise required under applicable law.

- If you become divorced or legally separated, certain court orders could require that part of your benefit be paid to someone else—your former spouse, for example. This is known as a "Qualified Domestic Relations Order". As soon as you are aware of any court proceedings that may affect

your pension benefit, contact the Bay State Gas Pension Source at **1-877-587-5866**.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be paid to someone who is authorized to manage your affairs. This may be a relative, a friend or a court-appointed guardian.

If the Plan Becomes "Top-Heavy"

As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60% of accumulated benefits are payable to certain "key employees." Key employees are officers with annual compensation of more than $130,000, and highly paid employees who are 1 percent-owners of the Company with annual compensation of more than $150,000, 5 percent-owners of the Company and beneficiaries of the above. You will be notified if this affects you.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you, and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet, which explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility that can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a QDRO, you may file suit in federal court.

- If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the EBSA Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;
- Logging on to the Internet at www.dol.gov/dol/ebsa; or

- Contacting the EBSA field office nearest you.

No Guarantee

All benefits provided under the Plan will be paid solely from the assets of the trust associated with the Plan. Except to the extent provided by law, nothing in the Plan or the trust will constitute a guarantee by the Company that the assets of the trust will be sufficient to pay any pension benefits to any person. Nothing in the Plan will give you or your beneficiary an interest in any specific part of the assets of the trust, or any other interest, except the right to receive pension benefits out of the assets of the trust as provided for in the Plan.

If the Plan Ends

Bay State Gas Company ("Bay State") reserves the right to suspend, amend or terminate the Plan at any time. If the Plan is terminated, benefits generally would be paid as described in this section, to the extent funded.

If the Plan Is Amended

Bay State may make modifications or amendments to the Plan if appropriate or necessary. Amendments will normally not decrease your accrued benefit as of the time an amendment is adopted.

If the Plan Is Terminated

If the Plan is terminated, or if there is a partial termination affecting you, you immediately will be 100 % vested as of the date of the termination. Benefits will be paid, according to law, as described in the following section. Any money left in the trust will be returned to Bay State after all required benefit obligations have been met. Trust fund assets would be used first to provide benefits to retirees, beneficiaries and active participants.

Distribution of Benefits Upon Plan Termination

Before terminating the Plan, Bay State would be required to notify the Pension Benefit Guaranty Corporation, a federal government agency. You also would receive notice of this termination. Once approval has been received, Plan benefits would be paid in the order prescribed by law. If for any reason the funds are insufficient to pay full benefits to all participants, payments would be made as prescribed by law.

Benefits for certain highly paid employees may be limited when the Plan terminates. If this applies to you, you will be provided with details.

Mergers, Consolidations or Transfers

If the Plan is merged or consolidated with another plan, or if Plan assets are transferred to another plan, your accrued benefit will be protected. Your accrued benefit under the new plan would, immediately after the change, at least equal the amount you would be entitled to immediately before the merger if the Plan had terminated just before the change.

Pension Benefit Guaranty Corporation

Your pension benefits, under the Plan, are insured by the Pension Benefit Guaranty Corporation ("PBGC"), a federal insurance agency. If the Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers:

- Normal and early retirement benefits;
- Disability benefits if you become disabled before the Plan terminates; and
- Certain benefits for your survivors.

The PBGC guarantee generally does not cover:

- Benefits greater than the maximum guaranteed amount set by law for the year in which the Plan terminates;
- Some or all of benefit increases and new benefits based on Plan provisions that have been in place for less than five years at the time the Plan terminates;
- Benefits that are not vested because you have not worked long enough for the Company;
- Benefits for which you have not met all of the requirements at the time the Plan terminates;
- Certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and
- Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay and severance pay.

Even if a portion of your benefits is not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money the Plan has and on how much the PBGC collects from the Company.

For more information about the PBGC and the benefits it guarantees, contact the PBGC's Technical Assistance Division,
1200 K Street NW, Suite 930, Washington DC 20005-4026 or call **1-202-326-4000** (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at **1-800-877-8339** and ask to be connected to **1-202-326-4000.**

Additional information about the PBGC's pension insurance program is available through the PBGC's Web site on the Internet at **www.pbgc.gov**.

Administrative Information

Plan Sponsor
The Plan Sponsor is Bay State Gas Company

Plan Administrator
Bay State Gas Company
Benefits Committee
Bay State Gas Company
300 Friberg Parkway
Westborough, MA 01581-5039

Employer Identification Number

The Employer Identification Number ("EIN") assigned by the IRS for Bay State is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined benefit plan generally providing pension benefits to eligible retirees and their survivors, and has been assigned Plan number 010. The official Plan name is the Pension Plan for Operating Employees of Bay State Gas Company.

Plan Year
The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is The Northern Trust Company. The Plan Trustee is responsible for holding the assets of the trust fund according to the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

You may contact the trustee at:

The Northern Trust Company
50 South LaSalle Street
Chicago, IL 60675

Agent for Service of Legal Process

The agent for service of legal process is:

Clerk
Bay State Gas Company
300 Friberg Parkway
Westborough, MA 01581-5039

Legal process may also be served on the Plan administrator or the trustee.

Collective Bargaining Agreement

Your benefits under the Plan are subject to the following collective bargaining agreement:

Location	Union/Local	Term of Collective Bargaining Agreement
Springfield, MA	United Steelworkers of America, AFL-CIO-CLC Local 12026 2025 Roosevelt Ave Springfield, MA 01102-2025	May 15, 2004 - May 15, 2013

NiSource Inc. Retirement Savings Plan

(Bay State Gas Company Employees)

Summary Plan Description (SPD)

Plan #005

DRAFT
DOCUMENT FOR
DISCUSSION
PURPOSES ONLY

This document constitutes part of a Section 10(a) Prospectus covering securities that have been registered under the Securities Act of 1933.
May 1, 2004

Contents

As a non-union employee of Bay State Gas Company or any affiliate that adopts the Plan for its employees (collectively, "Company"), you are eligible to enroll in the NiSource Inc. Retirement Savings Plan ("Plan") on the date of your hire provided you have satisfied the criteria described in the Eligibility and Enrollment sections.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of May 1, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion.

The Plan

The Plan offers you these features:

- You are always 100% vested in your own contributions to your Account.
- You can contribute from 1% to 50% of your eligible pay on a pre-tax basis and up to 25% on after-tax basis, subject to IRS limitations.
- The Company matches a portion of your pre-tax contributions every payroll period. ("Catch-up" contributions are not matched.) The Company may match a portion of your after-tax contribution (see the "Company Matching Contribution" section).
- You are always 100% vested in your Company matching contributions and profit participation contributions.
- You can make "catch-up" contributions commencing in the year you turn age 50.
- You decide how your contributions are invested among a variety of investment options.
- You have the option to borrow from your Plan Account in accordance with the Plan loan procedures.
- You may request a withdrawal from your rollover or after-tax contributions at any time, which may be subject to tax consequences.
- If you leave the Company, you can elect to defer payment of, take a lump sum distribution of, or roll over your Account.
- If you die, your designated beneficiary or beneficiaries will be eligible to receive your total Plan Account.
- You can call Fidelity Benefits Service Center at 1-800-305-4015 for your Account information, 24 hours a day, seven days a week. You can also visit your Account online at NetBenefits at **www.401k.com**.

Eligibility and Enrollment

Generally, you are immediately eligible to participate with your first pay period after your employment commences if you are a regular full-time, part-time or temporary employee (leased employees and independent contractors are not eligible). If you elect not to enroll immediately, you may enroll as of any subsequent pay period.

As a newly eligible participant, you will receive an enrollment packet with the enrollment, beneficiary designation and investment option forms. You may enroll in the Plan online at

NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015. To enroll, you will need to:

- Set up a Personal Identification Number (PIN).
- Elect what percentage of your compensation you want to contribute to the Plan.
- Elect if your contributions should be deducted from your pay on a pre-tax and/or an after-tax basis.
- Elect the funds in which you want your money to be invested.

You will receive a written confirmation of the elections you make when you enroll in the Plan within 7 to 10 business days after enrolling.

Your actual payroll deductions will begin as soon as administratively possible.

When Participation Begins

You must enroll in the Plan to participate. To enroll, you can log on to NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015. Typically, you can expect your deductions to begin one or two pay periods after you enroll. Please note: you cannot "catch up" for pay periods that occurred prior to your enrollment being processed.

In addition, you will be requested to name a beneficiary for your Plan Account. Your beneficiary is the person or persons who will receive your Account balance if you die before receiving it. You may choose anyone as your beneficiary. However, if you are married and you want to name someone other than your spouse as your beneficiary, current federal law requires that you must obtain your spouse's written consent. Your spouse's consent, if given, must be witnessed by a notary public or a Plan representative.

If you fail to designate a beneficiary, your benefits will be payable as follows:

- To your surviving spouse, or if none,
- To your descendants, or if none,
- To your father and mother, in equal parts, or if none,
- To your brothers and sisters, in equal parts, or if none,
- To your estate.

You will be eligible for the Company matching contribution immediately upon enrollment to the Plan. For further information regarding the Company matching contribution, please refer to "Company Matching Contribution" later in this document.

When Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- The Company terminates its participation in the Plan;
- The Plan ends; or
- You die.

Highlights of the Plan

Maximum pre-tax contribution for 2004 is $13,000. The amount increases by $1,000 each year thereafter, until it reaches $15,000 in 2006.

	Pre-tax Contributions	**After-Tax Contributions**
Vesting	100% vested in your pre-tax contributions, Company contribu-tions made to your Account and earnings	100% vested in your after-tax contributions and earnings
Employee Contribution	Can choose to contribute from 1% to 50% of your compensation, subject to annual IRS limits.	Can choose to contribute up to 25% of your compensation, subject to annual IRS limits (your combined pre & after-tax contributions cannot exceed 75%)
Company Contributions	See "Company Matching Contributions" and "Profit Participation Contributions"	See "Company Matching Contributions"
Eligible Compensation	See "Compensation"	See "Compensation"
"Catch-up" contributions at and after age 50	$3,000 in 2004 $4,000 in 2005 $5,000 in 2006 After 2006, the annual limit is adjusted for inflation in $500 increments. *Catch-up contributions are not eligible for match.*	N/A
Tax Advantages	Current tax savings on contributions and earnings	Current tax savings on earnings only
Loans	Loans are available, subject to IRS rules and Plan restrictions	Loans are available, subject to IRS rules and Plan restrictions
In-Service Withdrawals	• After age 59-1/2 • Matching contributions, under certain circumstances • Hardships	• Withdrawals of after-tax contributions can be made for any reason.
Distribution Options	• Lump Sum • Installments • Various Annuities for portion of Account attributable to prior plan	• Lump Sum • Installments • Various annuities for portion of Account attributable to prior plan
Survivor Benefit	Yes	Yes

Compensation

The components of your compensation depend on whether you participate in the Final Average Pay Option or the Account Balance Option of the Bay State Gas Company Pension Plan ("Pension Plan").

— If you participate in the Final Average Pay Option of the Pension Plan, your compensation is your aggregate basic annual salary or wage, bonus, commissions, overtime, sick pay and shift differential including pre-tax contributions to the Plan, qualified transportation fringe benefits under Section 132(f)(4) of the Internal Revenue Code ("Code") and deferrals under Section 125 of the Code.

— If you participate in the Account Balance Option of the Pension Plan, your compensation is your aggregate basic annual salary or wages and commissions.

In addition, your compensation for the year in which you terminate employment with the Company and its affiliates will include any amounts attributable to "banked" vacation under the NiSource Vacation Policy, dated January 1, 2004.

The IRS limits the amount of your compensation that can be considered under the Plan. The limit is $205,000 for 2004 and $210,000 for 2005.

Contributions To The Plan
Pre-Tax and After-Tax Contributions

As an eligible participant, you can contribute to the Plan through payroll deductions from 1 percent to 50 percent of your compensation on a pre-tax basis and up to 25 percent on an after-tax basis. Your combined pre-tax and after-tax contributions cannot exceed 75 percent of your compensation (subject to annual IRS limits).

The maximum amount you may contribute annually to the Plan on a pre-tax basis for 2004 is $13,000. This amount will increase by $1,000 each year thereafter until it reaches $15,000 in 2006. After 2006, the maximum amount will be adjusted by the IRS for inflation in $500 increments.

Catch-Up Contributions

If you reach age 50 during the calendar year and you are making the maximum Plan or Code pre-tax contribution, you may make an additional "catch-up" contribution each pay period. Maximum annual catch-up contributions are as follows:

- $3,000 in 2004
- $4,000 in 2005
- $5,000 in 2006

After 2006, the annual limit will be adjusted by the IRS for inflation in $500 increments. Please note that these "catch-up" contributions are not matched by the Plan.

Changing Your Contributions

You may change the amount you are contributing at any time during the year, subject to any IRS limits that may apply. To increase or decrease the amount you are contributing or to suspend your contributions, go online to NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015.

Transactions are processed the same business day for transactions made by 4 p.m. Eastern time and the end of the next business day if you make a transaction after 4 p.m., or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days. It can take up to two payroll checks for your contribution change to be processed.

Rollover Contributions

You are permitted to roll over pre-tax contributions from other qualified plans such as:

- Qualified retirement plans
- Individual Retirement Accounts (IRAs)
- 403(b) plans
- Governmental 457(b) retirement plans

By rolling over the money, you can continue to defer federal and state income tax on the money until you ultimately receive it. Rollovers must be at least $250. Rollovers are deposited into a Rollover Contribution Account within your Plan Account. You will not receive a matching contribution on any rollover you make to the Plan. If you want to arrange a rollover, call Fidelity Benefits Service Center at 1-800-305-4015 for more information.

Company Matching Contributions

The Company matching contribution you receive depends on whether you participate in the Final Average Pay Option or the Account Balance Option of the Pension Plan.

— If you participate in the Final Average Pay Option of the Pension Plan and you are eligible for post-retirement medical benefits under the Pension Plan, the Company matching contribution will equal 50% of your pre-tax contributions each pay period, up to 5% of your total compensation for that pay period.

— If you participate in the Final Average Pay Option of the Pension Plan and you are not eligible for post-retirement medical benefits under the Pension Plan, the Company matching contribution will equal 100% of your pre-tax contributions each pay period up to 2.5% of your

total compensation, and 50% of your pre-tax contributions each pay period on the next 5% of your total compensation, for that pay period.

— If you participate in the Account Balance Option of the Pension Plan, the Company matching contribution will equal 75% of your pre-tax and after-tax contributions each pay period, up to 6% of your total compensation for that pay period.

All Company matching contributions will be made to the NiSource Stock Fund. Once the matching contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

Maximizing Your Company Matching Contribution

The Company matching contribution is made each pay period. If you reach the IRS limit on pre-tax contributions and the combined Plan limit on after-tax and pre-tax contributions, you will no longer receive a Company matching contribution for the remainder of that calendar year. Therefore, if you want to maximize your Company matching contributions, you need to spread your after-tax and/or pre-tax contributions evenly throughout the year.

Profit Participation Contributions

Each year, the Company, in its sole discretion, may make a profit participation contribution of up to 1.5% of compensation for each employee who is eligible to participate in the Plan. You will receive this contribution each year, if any, whether or not you make contributions to the Plan, as long as you are employed by the Company on the last day of the year, or you retired, became disabled or died during the year. All profit participation contributions will be made to the NiSource Stock Fund. Once the profit participation contributions are in your Account, you may diversify them among any of the investment options available under the Plan.

Your Investment Options

The Plan offers a variety of investment options, each with a different objective. At the time of your enrollment, you must make your investment choices in whole 1% increments. For more complete information on the Plan's investment options, including historical fund performance, fees and expenses visit Fidelity NetBenefits at www.401k.com and click on the Asset Allocation Worksheet in the "Tools" section, or visit the interactive tools on NetBenefits at www.401k.com. Additional help is available by calling the Fidelity Benefits Service Center at 1-800-305-4015.

The Company matching contributions and profit participation contributions you receive are automatically invested in the NiSource Stock Fund. You can redirect that money into any of the other investment options available under the Plan.

You can elect whether to reinvest your dividend from the NiSource Stock Fund or receive it in cash. However, if the dividend is less than $10, it will automatically be reinvested. If you do not make an election, your dividend will automatically be reinvested.

If you elect to receive your dividend in cash, it will be subject to income taxes in the year you receive it. However, it is not subject to the 10% penalty tax that applies to premature distributions from your Plan. No taxes will be withheld from your dividend check. You will be responsible for making all tax payments when you file your income tax return.

To make an election, contact Fidelity Benefit Service Center at 1-800-305-4015.

Changing Your Investment Election

You may make investment transfers (reallocations) at any time. You can move in percentages, dollar amounts, or number of shares among investment options. To make transfers in your Account, log on to NetBenefits at www.401k.com, or contact the Fidelity Benefits Service Center at 1-800-305-4015.

There is no limit to the number of times you may change your investment elections per year, but you can make only one change per day. Transactions are processed the same business day for transactions made by 4 p.m. Eastern time and the end of the next business day if you make a transaction after 4 p.m. Eastern time, or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days.

Additional Information Relating To The Investment Options

Investment Funds

The value of Plan Accounts invested in a fund other than the NiSource Stock Fund will be net of any investment manager fees that may be charged with respect to that particular fund. The prospectus for each fund describes the fees and expenses associated with investing in that fund. You will not be charged any fees or expenses with respect to investments in the NiSource Stock Fund.

Equity securities in the funds, except for the NiSource Stock Fund, will be voted by the trustee. If you have invested in the NiSource Stock Fund, you are entitled to exercise any voting, tender or similar rights attributable to the shares of NiSource stock that are allocated to your Account. The Company will furnish the trustee with notices and information statements when voting, tender and similar rights are to be exercised. The trustee will notify you of each occasion for the exercise of voting, tender and similar rights and will forward copies of any proxy material within a reasonable time after it is secured from the Company. You may elect to exercise your right by filing written voting or tender instructions with the trustee at the time and in the form specified by the trustee. Any instructions that you submit to the trustee will be held in the strictest confidence and will not be divulged or released to any person including officers, directors or employees of the Company. The Plan administrator will establish procedures designed to safeguard the confidentiality of information as to your purchase, holding and sale of interests in the NiSource Stock Fund, and your exercise of voting, tender and similar rights with respect to common stock held therein (except to the extent necessary to comply with federal laws or with state laws that are not preempted by ERISA). The trustee will not vote or tender shares of NiSource stock allocated to your Account if it does not receive your instructions by the specified deadline.

If you exercise your tender rights, the proceeds obtained when your shares of NiSource stock are sold will be invested in the investment funds, other than the NiSource Stock Fund, in the same proportions as are included in your investment election on file with the Plan.

Accounting Methods Used for Recordkeeping

The Plan uses units rather than shares to account for contributions to the NiSource Stock Fund. This means that your investment in these funds is maintained in units, not actual shares. Each unit has a value that is calculated by dividing the total market value of the fund by the total number of units held in the fund. The number of units you hold in the fund increases or decreases as you make contributions, withdrawals, or transfers into or out of the fund. The value of your Account in the fund at any time is equal to the unit value multiplied by the number of units you hold. To find out the approximate number of actual shares of stock represented in the NiSource Stock Fund, divide the fund value by the current share price of the NiSource stock.

The other investment funds are subject to share accounting, which means that your investment in these funds is maintained in actual shares of the fund. Thus, shares are bought and sold to cover your contributions, withdrawals or transfers into or out of the fund.

Purchases and Contributions of NiSource Stock

NiSource stock is listed on the New York Stock Exchange. The Plan will generally purchase shares of NiSource stock as soon as administratively possible after the trustee receives Company or participant contributions that are to be invested in the NiSource Stock Fund. The Plan also will generally purchase or sell NiSource stock as soon as administratively possible after it receives any election by a participant to transfer amounts into or out of this investment option. Each such purchase or sale will be made at the market price for the stock on the New York Stock Exchange at the time of the purchase or sale.

Section 16 of the Securities Exchange Act of 1934

If you are subject to the short-swing profit provisions of Section 16 of the Securities Exchange Act of 1934 (an "insider"), you may be limited in your ability to purchase and sell NiSource stock under the Plan. Further information covering the operation of Section 16 to insiders will be provided by NiSource.

Resale Restrictions

Although NiSource has registered the sale of NiSource stock pursuant to the Plan, special restrictions may apply to the resale of the shares distributed to you from the Plan if you are an "affiliate" of NiSource at the time of the resale, as such term is used in Rules 144 and 405 of the Securities Act of 1933. An affiliate may not reoffer or resell such shares without further registration under the Securities Act of 1933 unless the reoffer or resale is pursuant to an applicable exemption, such as Rule 144. Generally, only the NiSource's executive officers would be considered affiliates of NiSource. Any person who may be an affiliate may wish to consult with legal counsel before transferring any NiSource stock.

For More Information About Plan Investments

Additional information about the investment options offered by the Plan is available upon request. You may request information regarding each investment option (*e.g.*, annual operating expenses, prospectus documents, financial statements, reports and other materials) by contacting Fidelity Benefits Service at (800) 305-4015 or visit the interactive tools on NetBenefits at www.401k.com.

AVAILABLE INFORMATION

On August 7, 2003, NiSource filed a Registration Statement on Form S-8 ("Registration Statement") with the SEC covering up to 1,492,416 shares of NiSource stock to be offered and sold under the Plan. These Shares were previously registered on Post-Effective Amendment No. 11 on Form S-8 to Registration Statement on Form S-4 (File Nos. 333-33896 and 333-33896-01). Those shares consisted of the following number of registered shares which remain available for issuance: 893,370 shares under the NiSource Inc. Tax Deferred Savings Plan, 570,046 shares under the Bay State Gas Company Employee Savings Plan and 29,000 shares under the Kokomo Gas & Fuel Co. Bargaining Unit Tax Deferred Savings Plan. These plans were merged into the Columbia Savings Plan (7,285,958 registered shares remaining at that time) effective January 1, 2002, at which time the Columbia Savings Plan was renamed the NiSource Inc. Retirement Savings Plan.

NiSource and the Plan are required to file documents with the SEC pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities and Exchange Act of 1934. All such documents filed by NiSource or the Plan after the effective date of this SPD will be considered incorporated by reference in the Registration Statement and this SPD until NiSource or the Plan files a post-effective amendment that states that all NiSource stock offered by the Registration Statement has been sold, or deregisters all NiSource stock that remains unsold.

The Company will provide, without charge to each Plan participant, upon his or her written or oral request: (i) a copy of any of the documents incorporated by reference in the Registration Statement other than exhibits to such documents which are not specifically incorporated by reference into the information that this document incorporates, and (ii) a copy of NiSource's Annual Report to Shareholders for its most recent fiscal year. Requests for copies of these documents should be directed to Ask Gloria

Loans

You may apply for a loan from the Plan while you are still an active employee by logging on to NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015.

When you take a loan from the Plan, you are borrowing from yourself and paying your Account back with interest. If you pay your loan back as agreed, your loan is not subject to income or penalty taxes.

- You may borrow from your account for any reason.

- You may have up to two loans outstanding at any time.
- The minimum loan amount is $1,000.
- The maximum loan amount is the lesser of: (1) $50,000 reduced by any outstanding loan balances over the previous 12 months; and (2) 50 percent of your total vested Account balance.
- Loan repayments, plus interest, are automatically deducted from your paycheck through after-tax payroll deductions.
- Loans are taken from your investment options on a pro rata basis.
- The loan term can be from one to five years (15 years if the loan is to purchase your primary residence), as long as you will receive a paycheck in an amount at least as much as the loan repayment each pay period. You may also make a lump-sum repayment of your loan at any time.
- The interest rate applied on these loans is the prime rate published in *The Wall Street Journal* on the last day of the previous month.
- You can prepay your loan(s) in full and without penalty at any time.
- If you fail to make any required loan payments, the balance of your loan (and any other charges or expenses incurred because of your default) will be treated as a taxable distribution to you on your default date and will be deducted from your Plan Account.
- If your employment with the Company terminates, the remaining balance of your loan will become due and payable within 90 days. If payment is not received within 90 days, your outstanding balance will automatically default.
- Loans are processed and serviced by Fidelity. A $35 loan origination fee and a $3.75 quarterly fee will be deducted from your Account for each loan.
- Typically, you can expect to receive a check within five to eight business days after your loan is approved. Your signature on the back of the check will indicate your approval of the loan terms contained in the accompanying paperwork.
- If your first loan is defaulted, you are not eligible for a second loan unless you re-pay the first loan's outstanding balance.

When you request a loan, there is a certain order among the different types of contributions in your account that the loan is taken from. Funds for your loan are withdrawn in the following order:

- Your pre-tax contributions
- **[Your catch-up contributions]** Gloria to confirm order
- Company contributions

- Your after-tax contributions (including any prior lump-sum deposits you made to the Plan)
- Rollover contributions

And, when you repay the loan, the order is reversed; payback starts with your rollover contributions.

In-Service Withdrawals

The Code and the Plan restrict the types of withdrawals you may make while actively at work. They are

- 59-1/2 withdrawals,
- Voluntary withdrawals from after-tax, rollover and Company matching contributions, and
- Hardship withdrawals.

You can request a minimum withdrawal of $250 (or your entire balance, if lower). Only two in-service withdrawals may be made in any 12-month period.

Distributions will be taxed as ordinary income in the year withdrawn and may also be subject to an early withdrawal penalty if taken before age 59-1/2, unless eligible rollover distributions are rolled over to another qualified plan or an IRA. (This excludes any withdrawals of after-tax contributions.) A 20% mandatory federal income tax withholding applies to withdrawals that are eligible for rollover that are not directly rolled over to another qualified plan or an IRA.

For more information or to request a withdrawal, log on to NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015.

Withdrawals After Age 59-1/2

Once you reach age 59-1/2, you can withdraw up to the full value of your Account for any reason.

Voluntary Withdrawals
(After-Tax, Rollover, Company Matching Contributions and Profit Participation Contributions)

If you have made after-tax and/or rollover contributions to the Plan, you may make a full or partial withdrawal of those funds while you are an active employee. Although you are not taxed on the withdrawal of your after-tax contributions, you will be taxed on your rollover contributions and earnings on after-tax and rollover contributions.

All of your after-tax deposits made to the Plan before January 1, 1987 can be withdrawn during active employment for any reason with no taxes applied to the withdrawal.

Your after-tax deposits made to the Plan after December 31, 1986 can also be withdrawn for any reason, but they are not free from taxes. Once you have withdrawn all pre-1987 after-tax contributions, a portion of each subsequent withdrawal of after-tax contributions may be considered investment earnings and will be taxable.

You may withdraw any portion or all of your Company matching contributions from your Account, if you have been a participant in the Plan for at least 60 months. If you have been a participant in the Plan for less than 60 months, you may withdraw any or all Company matching contributions and/or profit participation contributions that exceed the Company matching contributions and/or profit participation contributions that have been allocated to your Account during the current Plan year and the two previous Plan years. If you are withdrawing Company matching contributions and/or profit participation contributions, you will be taxed on your withdrawal, and your contributions will be suspended for a period of six months. To restart your contributions, you must call Fidelity at **1-800-305-401K** (1-800-305-4015).

Withdrawals are funded by a pro rata withdrawal from your investment options. Withdrawals from the NiSource Stock Fund may be made in cash and/or stock at your request. Withdrawals from any other investment option are made in cash.

Hardship Withdrawals

You can withdraw up to your entire Account balance (except for earnings on your pre-tax contributions from and after January 1, 1989) for financial hardships as defined by the IRS. *Investment earnings cannot be withdrawn until you reach age 59-1/2 or leave NiSource.*

IRS regulations currently define hardship withdrawals as:

- Purchase of your primary residence (but not mortgage payments).
- Tax deductible medical expenses for yourself, your spouse or your dependents.
- Tuition and related educational fees (including room and board) for up to the next 12 months of post-secondary education for yourself, your spouse or your dependents.
- Prevention of eviction from, or foreclosure on, your primary residence.
- Funeral expenses for your spouse or your dependents.

You will have to provide documentation of the hardship showing an immediate and serious financial need and the amount required to meet the hardship. Your withdrawal cannot be more than the amount required to meet the financial hardship, plus a reasonable estimate of amounts needed to pay federal, state or local income taxes or penalties, up to certain limits.

When you take a hardship withdrawal, the IRS and the Plan also impose certain other rules that will affect your Plan participation:

- Any portion of your Account balance being used as security for the Plan loan may not be taken as a hardship withdrawal.

- If you can take a loan from the Plan, you must take a loan up to the maximum amount available prior to applying for a hardship withdrawal—unless repaying the loan in itself would be a hardship.

- You will need to withdraw any available after-tax contributions, rollover contributions and Company matching contributions, to the extent available, plus the earnings on those contributions first.

- If you take a hardship withdrawal, you will not be allowed to contribute to the Plan for six months. Following the six-month suspension period, you may re-enter the Plan at any time. You must call Fidelity Benefits Service Center at 1-800-305-4015.

- You will also need to sign a statement indicating that other financial resources have been exhausted.

Order of In-Service Withdrawals

Your withdrawal will be taken from your contributions in the following order up to the amount you requested:

- Your after-tax contributions (including any prior lump-sum contributions)

- Rollover contributions

- Company contributions

- Your pre-tax contributions

- Your catch-up contributions

When Your Benefit is Paid

You or your beneficiaries are entitled to receive the full value of your Account as soon as possible after:

- You terminate employment with the Company,

- You die, or

- You qualify for disability under the Plan.

You can elect to receive the value of your Account or, if your Account value is over $5,000, you may defer payment to a later date. *If you defer payment to a later date, your Account will remain invested in the Plan's investment options. You can change your investment option election at any time under the regular rules of the Plan.*

If you do not request payment, your Account will be distributed 60 days after the end of the Plan year in which the latest of the following events occurs:

- The day you reach age 65;
- The tenth anniversary of the date you last began participating in the Plan; or
- Your last day of employment with the Company.

You may request that your Account in the NiSource Stock Fund be paid to you in shares of NiSource common stock, in cash or in a combination of the two.

If you die before receiving the value of your Account, it will be transferred to your spouse or other beneficiary you have named under the rules of the Plan, provided the proper forms have been filed.

Designation of Beneficiary

When you enroll in the Plan or make a rollover contribution, you should name a beneficiary (someone to receive your benefits from the Plan in the event of your death) by completing a beneficiary designation form that is included in the enrollment packet and submitting it to Fidelity P.O. Box 770003 Cincinnati, OH 45277-0065.

You may designate anyone as your beneficiary. If you are married, your spouse is automatically your beneficiary unless you designate someone else, in which case your spouse must give his or her consent by signing the beneficiary designation form in the presence of a notary public or a Plan representative.

You may change your beneficiary at any time by submitting a new form. However, if you name someone other than your spouse, your spouse must give his or her consent by signing the beneficiary designation form in the presence of a notary public or a Plan representative.

Your beneficiary may request payment of your Plan Account in a single lump sum or installments (see "Distribution Options"). Payments to your beneficiary, other than your spouse, must begin by December 31st of the calendar year following the calendar year of your death. If your beneficiary is your spouse, payments must begin by April 1 of the year following the date you would have reached age 70-1/2.

Forms of Distribution

- Lump Sum
- Installments (annual, semi-annual, quarterly or monthly)

Unless you elect otherwise, the balance of your Account invested in the NiSource Stock Fund will be distributed in installments of not more than five years (unless such balance exceeds a certain limit).

If your Account balance is $5,000 or less and no distribution election form has been completed, your Account will automatically be paid to you (or your beneficiary, if applicable) in a lump sum after your termination of employment (or death).

Effective March 28, 2005, if your Account balance is $1,000 or less when you terminate employment, the Company automatically pays you a lump sum. If your Account balance is greater than $1,000 but less than or equal to $5,000 when you terminate employment and no distribution election form has been completed, the Plan Administrator will roll over your Account balance to an individual retirement plan designated by the Plan Administrator.

TAX IMPLICATIONS OF PARTICIPATION IN THE PLAN

The discussion of Federal income tax consequences that follows is included for general information only and reflects the provisions of the Internal Revenue Code as in effect on May 1, 2004. The discussion does not describe all relevant tax matters (such as state and local income and inheritance taxes and federal estate and gift taxes) that should be considered in connection with participation in the Plan and does not completely describe all provisions associated with the tax matters discussed. Accordingly, you are advised to consult a personal tax adviser for tax planning relevant to the Plan and are further advised not to rely exclusively on the discussion that follows.

Contributions

The Plan is a qualified plan under Sections 401(a), 401(k) and 401(m) of the Internal Revenue Code. As a result, the amount of your Compensation that you elect to defer under the Plan through pre-tax contributions, and the Company matching contributions and rollover contributions, and any earnings thereon, are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts. The amount of your pre-tax contributions will, however, be included in your income in the year in which these amounts are considered earned for purposes of Social Security (FICA) taxes. In addition, some states, cities or counties may impose taxes on your pre-tax contributions.

Although after-tax contributions are deducted from your compensation after all applicable taxes have been withheld, the earnings on such contributions are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts.

Distributions

You generally can roll over a distribution or withdrawal of your Account to an eligible retirement plan of another employer or to an IRA, if the distribution is an “eligible rollover distribution” as defined in the Code. In such event, the amount rolled over and earnings thereon are not subject to income tax until subsequently distributed to you or your beneficiary. Any taxable amount of an eligible rollover distribution that is not rolled over will be subject to a mandatory 20% withholding requirement. See “Income Tax Withholding” below.

An additional 10% excise tax will be imposed on any taxable distribution or withdrawal you receive before you reach age 59-1/2, unless the distribution or withdrawal is (1) rolled over to another

eligible retirement plan or to an IRA, (2) made to a beneficiary after your death, (3) made on account of your retirement due to disability, (4) made after separation from service after you attain age 55, (5) made to you for payment of medical expenses that could be deducted on your tax return, (6) paid in equal installments over your life or life expectancy or the lives or life expectancy of you and your beneficiary, or (7) made to an alternate payee pursuant to a qualified domestic relations order.

Note that these rules apply to in-service withdrawals as well as distributions upon termination of employment.

To the extent that you receive shares of NiSource stock, your tax liability is based on the cost to the Plan trust of purchasing the stock for the Company matching contributions to your account. This value is taxed at ordinary income tax rates. Tax on any gain is deferred until you actually sell the stock. At that time, any gain is taxed at the capital gains tax rate.

Lump Sum Distributions

If you receive a lump sum distribution and you were born before January 1, 1936, (1) you can make a one-time election to figure the tax on the distribution by using "10-year averaging" at 1986 rates; and (2) you may elect to have the part of your distribution that is attributable to your pre-1974 participation in the Plan (if any) taxed as long-term capital gain at a rate of 20%. You generally can elect this special tax treatment only once in your lifetime and if you have previously rolled over a payment from the Plan, you cannot use this special tax treatment for later payments from the Plan. You should consult your tax advisers as to your eligibility for and the manner of electing this special treatment.

Special Rules for In-Service Withdrawals of After-Tax Contributions

If you have after-tax contributions held in your Account, a withdrawal of any portion or all of your after-tax contributions and the earnings attributable thereto may be subject to Federal income tax as ordinary income. No portion of any such withdrawal will be subject to Federal tax, however, until the total amounts withdrawn by you after December 31, 1986 exceeds the amount of your after-tax Contributions made as of December 31, 1986. Thereafter, the amount of any such withdrawal subject to Federal income tax will be determined by multiplying the amount withdrawn by a fraction, the numerator of which is the total amount of the earnings then credited to your after-tax contributions subaccount and the denominator of which is the total value of your after-tax contribution subaccount at the time of such withdrawal.

ROLLOVERS

Most Plan distributions and withdrawals are subject to mandatory Federal income tax withholding. The Trustee is required to withhold 20% of the taxable portion of any "eligible rollover distribution," unless you elect to have the Trustee make a direct rollover of the distribution into another employer's eligible retirement plan that accepts rollovers, or to an IRA. A distribution or withdrawal is not an "eligible rollover distribution" and may not be rolled over, if it is (1) a series of substantially equal period installments over ten years or more, or over your life expectancy or the joint life expectancies of you and your beneficiary, (2) a required distribution due to your attainment of age 70-1/2 (or retirement if later), (3) a hardship distribution or (4) a distribution made to a non-spousal beneficiary.

A taxable distribution or withdrawal that is not an "eligible rollover distribution" is subject to voluntary Federal income tax withholding, which means that you can request that no withholding tax be deducted from your distribution.

Prior to receiving a distribution of any amounts from the Plan, you will receive a Notice of Tax Treatment to assist you in determining your tax liability. The rules governing the Federal income taxation of a distribution are complex and are subject to change, and you should seek the advice of your tax advisers in connection with a distribution from the Plan.

To make a direct rollover, you must contact Fidelity at **1-800-305-401K** (1-800-305-4015). A Fidelity representative will ask you for specific information on the IRA or the other employer's plan to which you are requesting the rollover and let you know if a rollover is available to you.

Situations Affecting Your Plan Benefits

This section describes how the Plan provides you or your beneficiary with benefits. It is important that you understand the conditions under which benefits could be less than expected or not paid at all or limited, including:

- If the investment funds you choose experience losses, the value of your contributions can decrease.

- If you are affected by total annual contribution or compensation limits under the Code, the amounts you and the Company contribute on your behalf may be limited. If you are affected by these limits, you will be notified.

- If the Plan does not pass required nondiscrimination testing, all or a portion of the contributions made on behalf of highly compensated employees may be reduced. Nondiscrimination testing is required by law to ensure a fair mix of contributions from and for employees at all income levels. If you are affected by these limits, you will be notified.

- If you fail to make proper application for benefits or fail to provide necessary information, your benefits could be delayed.

- If you do not keep your most recent address on file and the Company cannot locate you, your benefit payment may be delayed. Once you (or your beneficiary, if you die) provide a current address, benefit payments can be made.

- The IRS sets maximum limits on the amount you can contribute to your Account every year.

- Your Account belongs to you and may not be sold, assigned, transferred, pledged or garnisheed under most circumstances.

  However, if required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit may be assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights. As soon as you are aware of any court proceedings that may affect your Account, contact MySource

for Human Resources at **1-888-640-3320**. You and your beneficiaries may obtain, free of charge, a copy of the procedures governing QDROs from the Plan administrator.

- As required by law, alternate Plan provisions go into effect if the Plan becomes top-heavy. The Plan is "top-heavy" if more than 60 percent of accumulated Account balances are payable to certain "key employees." Key employees are employees who are officers of the Company with annual compensation greater than $130,000, 1 percent-owners of the Company with annual compensation greater than $150,000, 5 percent-owners of the Company and beneficiaries of the above. You will be notified if this affects you.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be directed to someone authorized to conduct your affairs. This may be a relative, a court-appointed guardian or some other person.

Claim Denial and Appeal Process

If your claim for a benefit under the Plan is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to MySource for Human Resources, which handles the day-to-day administration of the Plan at the following address:

[MySource for Human Resources
2300 Discovery Drive
P.O. Box 785003
Orlando, FL 32878-5003] **[GLORIA TO VERIFY THAT THIS INFORMATION IS CORRECT FOR 401(k) PLANS]**

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet that explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility which can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain from the Plan Administrator, once a year, a statement of your total benefits accrued and your nonforfeitable (vested) retirement benefits (if any), or the earliest date on which benefits will

become nonforfeitable (vested). The Plan may require a written request for this statement, but it must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a Qualified Domestic Relations Order (QDRO), you may file suit in federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the Employee Benefits Security Administration Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;
- Logging on to the Internet at **www.dol.gov/dol/ebsa;** or
- Contacting the EBSA field office nearest you.

A copy of the Plan document is on file at the NiSource corporate offices, 801 E. 86th Avenue, Merrillville, IN 46410. These documents may be read by you, your beneficiaries or your legal representatives at any reasonable time. Additionally, if you make a written request, you may receive a copy of the Plan document. You may be charged for the copies.

If you have any questions regarding either the Plan or this SPD, you should contact MySource for Human Resources at **1-888-640-3320**.

Additional Information

Dividends

Dividends on the shares of NiSource stock in the NiSource Stock Fund paid to your Account that you do not elect to receive in cash will be used to acquire additional shares of NiSource stock.

Plan Expenses

Administrative expenses of the Plan, including fees of the trustee, counsel, accountants or other experts appointed under the Plan, will be paid out of the trust to the extent not paid by the Company.

Plan Statements

As a Plan participant, you will receive a statement of your Plan Account quarterly from Fidelity that shows your Account balance as of the end of the most recent quarter. You can elect to receive your statement online. You can view your statement online beginning the day after the end of the quarter

and going back for 24 months. Check your statement to be aware of your Account activity. Please contact Fidelity within 60 days of receiving your statement if you think there is an error.

Your Account is valued by Fidelity at the close of every business day. You can call Fidelity at **1-800-305-401K** (1-800-305-4015) or log on to your account at **www.401k.com** seven days a week to review your current Account balance.

If the Plan Ends

The Company reserves the rights to suspend, amend or terminate the Plan at any time, in whole or in part. Generally, Account balances cannot be reduced except for investment losses, even by a Plan amendment. Termination of the Plan is unlikely, but if the Plan is terminated, your Account automatically will remain 100 percent vested. If any material changes are made to the Plan in the future, you will be notified.

Benefits Are Not Insured

The Plan is a defined contribution plan providing specifically defined levels of contributions. This type of plan is not eligible for benefit insurance through the Pension Benefit Guaranty Corporation ("PBGC"), and no particular dollar level of benefits is guaranteed. All of the contributions are deposited with the trustee. All payments of Plan benefits are made from the Plan's trust fund.

No Guarantee

Nothing in this SPD states or implies that participation in the Plan is a guarantee of continued employment with the Company, nor is it a guarantee that contribution levels will remain unchanged in future years.

Limiting Liability

The Plan is intended to meet the provisions of Section 404(c) under ERISA. This means that Plan fiduciaries (those responsible for administering the Plan) may be relieved of liability for losses resulting from your investment instructions.

As a Plan participant, you may request (and the Plan fiduciary must provide):

- A description of the annual operating expenses of each investment option (*e.g.*, investment management fees, administrative fees and transaction costs) which reduce the rate of return to participants, and the total amount of such expenses expressed as a percentage of the investment option's average net assets.

- Copies of any annual reports, financial statements and reports, and any other materials relating to the investment options available under the Plan, to the extent such information is provided to the Plan.

- A list of the assets in the portfolio of each investment option; the value of each asset (or the proportion of the investment option which it comprises); and the fixed-rate investment contracts, the name of the bank, savings and loan association, or insurance company issuing the contract, the term of the contract and the rate of return of the contract.

- Information concerning the value of shares or units in the available investment options, as well as the past and current investment performance determined, net of expenses, on a reasonable and consistent basis.

- Information concerning the value of shares or units in the investment options held in your Account.

Administrative Information

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attention: NiSource Inc. and Affiliates Retirement Plan
Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer I.D. Number

The Employer Identification Number ("EIN") assigned by the IRS and associated with the Plan is 35-2108964.

Plan Type, Name and Number

The Plan is classified as a defined contribution plan and has been assigned Plan #005. It also is a Code section 401(k) plan and an ERISA section 404(c) plan. The official Plan name is the NiSource Inc. Retirement Savings Plan.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is responsible for holding the assets of the trust fund according to the participants' and NiSource's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

The trustee for the Plan is:

Fidelity Management Trust Company
82 Devonshire Street
Boston, MA 02109

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Legal process may also be served on the Plan administrator or the trustee.

Bay State Gas Company Savings Plan for Operating Employees

Summary Plan Description (SPD)

Plan #011

DRAFT FOR DISCUSSION PURPOSES ONLY

Contents

As an operating employee of Bay State Gas Company ("Company") who is a member of any collective bargaining unit listed on Schedule A through K, you are eligible to enroll in the Bay State Gas Company Savings Plan for Operating Employees ("Plan") provided you have satisfied the criteria described in the Eligibility and Enrollment sections.

This handbook serves as the Summary Plan Description ("SPD") of the Plan described herein as of January 1, 2004. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official Plan document. The official Plan document is the governing document in the event that questions arise or if there is a conflict between the SPD and the official Plan document. While the Company intends to continue the Plan described in this handbook, the Company reserves the right to change, modify or discontinue the Plan and any of its terms at its discretion.

The Plan

The Plan offers you these features:

- You are always 100% vested in your own contributions to your Account.
- You can contribute from 1% to 50% of your eligible pay on a pre-tax basis and up to 25% on an after-tax basis, subject to IRS limitations.
- The Company matches a portion of your pre-tax contributions every payroll period. ("Catch-up" contributions are not matched).
- You are always 100% vested in your Company matching contributions.
- You can make "catch up" contributions commencing in the year you turn age 50.
- You decide how your contributions are invested among a variety of investment options.
- You have the option to borrow from your Plan Account in accordance with the Plan loan procedures.
- You may request a withdrawal from your rollover or after-tax contributions at any time, which may be subject to tax consequences.
- If you leave the Company, you can elect to defer payment of, take a lump sum distribution of, or roll over your Account.
- If you die, your designated beneficiary or beneficiaries will be eligible to receive your total Plan Account.
- You can call Fidelity Benefits Service Center at 1-800-305-4015 for your Account information 24 hours a day, seven days a week. You can also visit your account online at NetBenefits at **www.401k.com**.

Eligibility and Enrollment

Generally, you are eligible to participate as of the first day of the next month after completion of the applicable period of employment, for pre-tax and catch-up contributions, and as of the first day of the next month after 1 year of employment for matching contributions, as provided in Schedules A through K attached.

As a newly eligible participant, you will receive an enrollment packet with the enrollment, beneficiary designation and investment option forms. You may enroll in the Plan online at NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015. To enroll, you will need to:

- Set up a Personal Identification Number (PIN).
- Elect what percentage of your compensation you want to contribute to the Plan.
- Elect if your contributions should be deducted from your pay on a pre-tax and/or an after-tax basis.
- Elect the funds in which you want your money to be invested.

You will receive a written confirmation of the elections you make when you enroll in the Plan within 7 to 10 business days after enrolling.

Your actual payroll deductions will begin as soon as administratively possible.

When Participation Begins

You must enroll in the Plan to participate. To enroll, you can log on to NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015. Typically, you can expect your deductions to begin one or two pay periods after you enroll. Please note: you cannot "catch up" for pay periods that occurred prior to your enrollment being processed.

In addition, you will be requested to name a beneficiary for your Plan Account. Your beneficiary is the person or persons who will receive your Account balance if you die before receiving it. You may choose anyone as your beneficiary. However, if you are married and you want to name someone other than your spouse as your beneficiary, current federal law requires that you must obtain your spouse's written consent. Your spouse's consent, if given, must be witnessed by a notary public or a Plan representative.

If you fail to designate a Beneficiary, your benefits will be payable as follows:

- To your surviving spouse, or if none,
- To your children, in equal shares, (or if a child does not survive you, and that child leaves issue, the issue shall be entitled to that child's share, by right of representation); or
- To your estate.

For further information regarding the Company matching contribution, please refer to "Company Matching Contribution" later in this document.

When Participation Ends

Your participation in the Plan ends when:

- You are no longer an eligible employee;
- The Company terminates its participation in the Plan;

- The Plan ends; or
- You die.

Highlights of the Plan

The maximum pre-tax contribution for 2004 is $13,000. The amount increases by $1,000 each year thereafter, until it reaches $15,000 in 2006.

	Pre-tax Contributions	**After-Tax Contributions**
Vesting	100% vested in your pre-tax contributions, Company contributions made to your Account and earnings.	100% vested in your after-tax contributions and earnings.
Employee Contribution	Can choose to contribute from 1% to 50% of your compensation subject to annual IRS limits.	Can choose to contribute up to 25% of your compensation subject to annual IRS limits (your combined pre-tax & after-tax contributions cannot exceed 75%)
Company Contributions	See "Company Contributions"	See "Company Contributions"
Eligible Compensation	See "Compensation"	See "Compensation"
"Catch-up" contributions at and after age 50	$3,000 in 2004 $4,000 in 2005 $5,000 in 2006 After 2006, the annual limit is adjusted for inflation in $500 increments. *Catch-up contributions are not eligible for match.*	N/A
Tax Advantages	Current tax savings on contributions and earnings	Current tax savings on earnings only
Loans	Loans are available, subject to IRS rules and Plan restrictions	Loans are available, subject to IRS rules and Plan restrictions
In-Service Withdrawals	• After age 59-1/2 • Prior Company Account • Hardships	• Withdrawals of after-tax contributions can be made for any reason
Distribution Options	Lump Sum Installments	Lump Sum Installments
Survivor Benefit	Yes	Yes

Compensation

Your compensation includes your wages, tips or other compensation reported on your W-2 and salary reductions under specified Internal Revenue Code ("Code") Sections.

The IRS limits the amount of your compensation that can be considered under the Plan. The limit is $205,000 for 2004 and $210,000 for 2005.

Contributions To The Plan

Pre-Tax and After-Tax Contributions

As an eligible participant, you can contribute to the Plan through payroll deductions from 1 percent to 50 percent of your compensation on a pre-tax basis and up to 25 percent on an after-tax basis. Your combined pre-tax- and after-tax contributions cannot exceed 75 percent of your compensation (subject to annual IRS limits).

The maximum amount you may contribute annually to the Plan on a pre-tax basis for 2004 is $13,000. This amount will increase by $1,000 each year thereafter until it reaches $15,000 in 2006. After 2006, the maximum amount will be adjusted by the IRS for inflation in $500 increments.

Catch-Up Contributions

If you reach age 50 during the calendar year and you are making the maximum Plan or Code pre-tax contribution, you may make an additional "catch-up" contribution each pay period. Maximum annual catch-up contributions are as follows:

- $3,000 in 2004
- $4,000 in 2005
- $5,000 in 2006

After 2006, the annual limit will be adjusted by the IRS for inflation in $500 increments. Please note that these "catch-up" contributions are not matched by the Plan.

Changing Your Contributions

You may change the amount you are contributing at any time during the year, subject to any IRS limits that may apply. To increase or decrease the amount you are contributing or to suspend your contributions, go online to NetBenefits at www.401k.com or contact the Fidelity Benefits, Service Center at 1-800-305-4015.

Transactions are processed the same business day for transactions made by 4 p.m. Eastern time and the end of the next business day if you make a transaction after 4 p.m., or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days. It can take up to two payroll checks for your contribution change to be processed.

Rollover Contributions

You are permitted to roll over pre-tax contributions from other qualified plans such as:

- Qualified retirement plans
- Individual Retirement Accounts (IRAs)
- 403(b) plans
- Governmental 457(b) retirement plans

By rolling over the money, you can continue to defer federal and state income tax on the money until you ultimately receive it. Rollovers are deposited into a Rollover Contribution Account within your Plan Account. You will not receive a matching contribution on any rollover you make to the Plan. If you want to arrange a rollover, call Fidelity Benefits Service Center at 1-800-305-4015 for more information.

Company Matching Contribution

The Company matches your contributions based on your current collective bargaining agreement. See the attached Schedules A through K.

Maximizing Your Company Matching Contribution

The Company matching contribution is made each pay period. If you reach the IRS limit on pre-tax contributions, you will no longer receive a Company matching contribution for the remainder of that calendar year. Therefore, if you want to maximize your Company matching contributions, you need to spread your pre-tax contributions evenly throughout the year.

Your Investment Options

The Plan offers a variety of investment options, each with a different objective. At the time of your enrollment, you must make your investment choices in whole 1% increments. For more complete information on the Plan's investment options, including historical fund performance, fees and expenses visit Fidelity NetBenefits at www.401k.com and click on the Asset Allocation Worksheet in the "Tools" section, or visit the interactive tools on NetBenefits at www.401k.com. Additional help is available by calling the Fidelity Benefits Service Center at 1-800-305-4015.

You can elect whether to reinvest your dividend from the NiSource Stock Fund or receive it in cash. However, if the dividend is less than $10, it will automatically be reinvested. If you do not make an election, your dividend will automatically be reinvested.

If you elect to receive your dividend in cash, it will be subject to income taxes in the year you receive it. However, it is not subject to the 10% penalty tax that applies to premature distributions from your Plan. No taxes will be withheld from your dividend check. You will be responsible for making all tax payments when you file your income tax return.

To make an election, contract Fidelity Benefit Service Center at 1-800-305-4015.

Changing Your Investment Election

You may make investment transfers (reallocations) at any time. You can move in percentages, dollar amounts, or number of shares among investment options. To make transfers in your account, log on to NetBenefits at www.401k.com, or contact the Fidelity Benefits Service Center at 1-800-305-4015.

There is no limit to the number of times you may change your investment elections per year, but you can make only one change per day. Transactions are processed the same business day for transactions made by 4 p.m. Eastern time and the end of the next business day if you make a transaction after 4 p.m. Eastern time, or on the weekend or a holiday. You will receive a written confirmation of your transaction from Fidelity within 7 to 10 business days.

ADDITIONAL INFORMATION RELATING TO THE INVESTMENT OPTIONS

Investment Funds

The value of Plan Accounts invested in a fund other than the NiSource Stock Fund will be net of any investment manager fees that may be charged with respect to that particular fund. The prospectus for each fund describes the fees and expenses associated with investing in that fund. You will not be charged any fees or expenses with respect to investments in the NiSource Stock Fund.

Equity securities in the funds, except for the NiSource Stock Fund, will be voted by the trustee. If you have invested in the NiSource Stock Fund, you are entitled to exercise any voting, tender or similar rights attributable to the shares of NiSource stock that are allocated to your Account. The Company will furnish the trustee with notices and information statements when voting, tender and similar rights are to be exercised. The trustee will notify you of each occasion for the exercise of voting, tender and similar rights and will forward copies of any proxy material within a reasonable time after it is secured from the Company. You may elect to exercise your right by filing written voting or tender instructions with the trustee at the time and in the form specified by the trustee. Any instructions that you submit to the trustee will be held in the strictest confidence and will not be divulged or released to any person including officers, directors or employees of the Company. The Plan administrator will establish procedures designed to safeguard the confidentiality of information as to your purchase, holding and sale of interests in the NiSource Stock Fund, and your exercise of voting, tender and similar rights with respect to common stock held therein (except to the extent necessary to comply with federal laws or with state laws that are not preempted by ERISA). The trustee will not vote or tender shares of NiSource stock allocated to your Account if it does not receive your instructions by the specified deadline.

If you exercise your tender rights, the proceeds obtained when your shares of NiSource stock are sold will be invested in the investment funds, other than the NiSource Stock Fund, in the same proportions as are included in your investment election on file with the Plan.

Accounting Methods Used for Recordkeeping

The Plan uses units rather than shares to account for contributions to the NiSource Stock Fund. This means that your investment in these funds is maintained in units, not actual shares. Each unit has a value that is calculated by dividing the total market value of the fund by the total number of units held in the fund. The number of units you hold in the fund increases or decreases as you make contributions, withdrawals, or transfers into or out of the fund. The value of your Account in the fund at any time is equal to the unit value multiplied by the number of units you hold. To find out the approximate number of actual shares of stock represented in the NiSource Stock Fund, divide the fund value by the current share price of the NiSource stock.

The other investment funds are subject to share accounting, which means that your investment in these funds is maintained in actual shares of the fund. Thus, shares are bought and sold to cover your contributions, withdrawals or transfers into or out of the fund.

Purchases and Contributions of NiSource Stock

NiSource stock is listed on the New York Stock Exchange. The Plan will generally purchase shares of NiSource stock as soon as administratively possible after the trustee receives Company or participant contributions that are to be invested in the NiSource Stock Fund. The Plan also will generally purchase or sell NiSource stock as soon as administratively possible after it receives any election by a participant to transfer amounts into or out of this investment option. Each such purchase or sale will be made at the market price for the stock on the New York Stock Exchange at the time of the purchase or sale.

Section 16 of the Securities Exchange Act of 1934

If you are subject to the short-swing profit provisions of Section 16 of the Securities Exchange Act of 1934 (an "insider"), you may be limited in your ability to purchase and sell NiSource stock under the Plan. Further information covering the operation of Section 16 to insiders will be provided by the Company.

Resale Restrictions

Although NiSource has registered the sale of NiSource stock pursuant to the Plan, special restrictions may apply to the resale of the shares distributed to you from the Plan if you are an "affiliate" of NiSource at the time of the resale, as such term is used in Rules 144 and 405 of the Securities Act of 1933. An affiliate may not reoffer or resell such shares without further registration under the Securities Act of 1933 unless the reoffer or resale is pursuant to an applicable exemption, such as Rule 144. Generally, only NiSource's executive officers would be considered affiliates of NiSource. Any person who may be an affiliate may wish to consult with legal counsel before transferring any NiSource stock.

For More Information About Plan Investments

Additional information about the investment options offered by the Plan is available upon request. You may request information regarding each investment option (*e.g.*, annual operating expenses,

prospectus documents, financial statements, reports and other materials) by contacting Fidelity Benefits Service at (800) 305-4015 or visit the interactive tools on NetBenefits at www.401k.com.

AVAILABLE INFORMATION

On November 2, 2000, NiSource Inc. ("NiSource") filed a Registration Statement on Post-Effective Amendment No. 11 on Form S-8 to Registration Statement on Form S-4 (File Nos. 333-33896 and 333-33896-01) ("Registration Statement") with the SEC covering up to 518,000 shares of NiSource stock to be offered and sold under the Plan.

NiSource and the Plan are required to file documents with the SEC pursuant to Sections 13(a), 13(c), 14 and 15(d) of the Securities and Exchange Act of 1934. All such documents filed by NiSource or the Plan after the effective date of this SPD will be considered incorporated by reference in the Registration Statement and this SPD until NiSource or the Plan files a post-effective amendment that states that all NiSource stock offered by the Registration Statement has been sold, or deregisters all NiSource stock that remains unsold.

The Company will provide, without charge to each Plan participant, upon his or her written or oral request: (i) a copy of any of the documents incorporated by reference in the Registration Statement other than exhibits to such documents which are not specifically incorporated by reference into the information that this document incorporates, and (ii) a copy of NiSource's Annual Report to Shareholders for its most recent fiscal year. Requests for copies of these documents should be directed to _____Ask Gloria???

Loans

You may apply for a loan from the Plan while you are still an active employee by logging on to NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015.

When you take a loan from the Plan, you are borrowing from yourself and paying your Account back with interest. If you pay your loan back as agreed, your loan is not subject to income or penalty taxes.

You may borrow from your account for any reason.

- You may have up to two loans outstanding at any time.
- The minimum loan amount is $1,000.
- The maximum loan amount is the lesser of: (1) $50,000 reduced by any outstanding loan balances over the previous 12 months; and (2) 50 percent of the total vested Account balance.
- Loan repayments, plus interest, are automatically deducted from your paycheck through after-tax payroll deductions.

- Loans are taken from your investment options on a pro-rata basis.

- The loan term can be from one to five years (15 years if the loan is to purchase your primary residence), as long as you will receive a paycheck in an amount at least as much as the loan repayment each pay period. You may also make a lump-sum repayment of your loan at any time.

- The interest rate applied on these loans is the prime rate published in *The Wall Street Journal* at the time the loan is processed.

- You can prepay your loan(s) in full and without penalty at any time.

- If you fail to make any required loan payments, the balance of your loan (and any other charges or expenses incurred because of your default) will be treated as a taxable distribution to you on your default date and will be deducted from your Plan Account.

- If your employment with Company terminates, the Company has the right to demand payment of your loan.

- Loans are processed and serviced by Fidelity. A $35 loan origination fee and a $3.75 quarterly fee will be deducted from your Account for each loan.

- Typically, you can expect to receive a check within five to eight business days after your loan is approved. Your signature on the back of the check will indicate your approval of the loan terms contained in the accompanying paperwork.

- If your first loan is defaulted, you are not eligible for a second loan unless you re-pay the first loan's outstanding balance.

When you request a loan, there is a certain order among the different types of contributions in your account that the loan is taken from. Funds for your loan are withdrawn in the following order:

- Your pre-tax contributions

- Your catch-up contributions

- Company contributions

- Your Prior Company Account

- Your after-tax contributions (including any prior lump-sum deposits you made to the Plan)

- Rollover contributions

And, when you repay the loan, the order is reversed; payback starts with your rollover contributions.

In-Service Withdrawals

The Code and the Plan restrict the types of withdrawals you may make while actively at work. They are

- 59-1/2 withdrawals,
- Voluntary withdrawals from after-tax, rollover Account and your Prior Company Accounts, and
- Hardship withdrawals

You can request a minimum withdrawal of $250 (or your entire balance if lower). Only two in-service withdrawals may be made in any 12-month period.

Distributions will be taxed as ordinary income in the year withdrawn and may also be subject to an early withdrawal penalty if taken before age 59-1/2, unless eligible rollover distributions are rolled over to another qualified plan or an IRA. (This excludes any withdrawals of after-tax contributions.) A 20% mandatory federal income tax withholding applies to withdrawals that are eligible for rollover that are not directly rolled over to another qualified plan or an IRA.

For more information or to request a withdrawal, log on to NetBenefits at www.401k.com or contact the Fidelity Benefits Service Center at 1-800-305-4015.

Withdrawals After Age 59-1/2

Once you reach age 59-1/2, you can withdraw up to the full value of your Account for any reason.

Voluntary Withdrawals
(After-Tax Contributions, Rollover and Prior Company Accounts)

If you have made after-tax contributions and/or rollover contributions to the Plan, you may make a full or partial withdrawal of those funds while you are an active employee. Although you are not taxed on the withdrawal of your after-tax contributions, you will be taxed on your rollover contributions and earnings on after-tax and rollover contributions.

All of your after-tax deposits made to the Plan before January 1, 1987 can be withdrawn during active employment for any reason with no taxes applied to the withdrawal.

Your after-tax deposits made to the Plan after December 31, 1986 can also be withdrawn for any reason, but they are not free from taxes. Once you have withdrawn all pre-1987 after-tax contributions, a portion of each subsequent withdrawal of after-tax contributions may be considered investment earnings and will be taxable.

Withdrawals are funded by a pro-rata withdrawal from your investment options and are made in cash.

Hardship Withdrawals

You can withdraw up to your entire Account balance (except for earnings on your pre-tax contributions from and after January 1, 1989) for financial hardships as defined by the IRS. *Investment earnings cannot be withdrawn until you reach age 59-1/2 or leave the Company.*

IRS regulations currently define hardship withdrawals as:

- Purchase of your primary residence (but not mortgage payments).
- Tax deductible medical expenses for yourself, your spouse or your dependents.
- Tuition and related educational fees (including room and board) for up to the next 12 months of post-secondary education for yourself, your spouse or your dependents.
- Prevention of eviction from, or foreclosure on, your primary residence.
- Funeral expenses for your spouse or your dependents.

You will have to provide documentation of the hardship showing an immediate and serious financial need and the amount required to meet the hardship. Your withdrawal cannot be more than the amount required to meet the financial hardship, plus a reasonable estimate of amounts needed to pay federal, state or local income taxes or penalties, up to certain limits.

When you take a hardship withdrawal, the IRS and the Plan also impose certain other rules that will affect your Plan participation:

- Any portion of your Account balance being used as security for a Plan loan may not be taken as a hardship withdrawal.
- If you can take a loan from the Plan, you must take a loan up to the maximum amount available prior to applying for a hardship withdrawal—unless repaying the loan in itself would be a hardship.
- You will need to withdraw any available after-tax contributions, rollover contributions and Company matching contributions, to the extent available, plus the earnings on those contributions first.
- If you take a hardship withdrawal, you will not be allowed to contribute to the Plan for six months. Following the six-month suspension period, you may re-enter the Plan at any time. You must call Fidelity Benefits Service Center at 1-800-305-4015 to restart your contributions.
- You will also need to sign a statement indicating that other financial resources have beenexhausted.

Order of In-Service Withdrawals

For hardship withdrawals, your withdrawal will be taken from your contributions in the following order up to the amount you requested:

- Your after-tax contributions (including any prior lump-sum contributions)
- Rollover contributions
- Company contributions
- Your Prior Company Account
- Your pre-tax contributions
- Your catch-up contribution

For withdrawals after you reach age 59-1/2, unless you elect to have amounts taken from your after-tax contributions first, your withdrawal will be taken in the following order:

- Rollover contributions
- Your pre-tax contributions
- Your catch-up contributions
- Company contributions
- Your Prior Company Account
- Your after-tax contributions

Unless you elect to have amounts taken from your after-tax contributions first, any other in-service withdrawal will be taken from your contributions as follows:

- Rollover contributions
- Your Prior Company Account
- Your after-tax contributions
- Your catch-up contributions

When Your Benefit Is Paid

You or your beneficiaries are entitled to receive the full value of your account as soon as possible after:

- You terminate employment with the Company, or

- You die, or

- You qualify for disability under the Plan.

You can elect to receive the value of your Account or, if your Account value is over $5,000, you may defer payment to a later date. *If you defer payment to a later date, your Account will remain invested in the Plan's investment options. You can change your investment option election at any time under the regular rules of the Plan.*

If you do not request payment, your Account will be distributed 60 days after the end of the Plan year in which the latest of the following events occurs:

- The day you reach age 65; or

- Your last day of employment with the Company.

You may request that your Account in the NiSource Stock Fund be paid to you in shares of NiSource common stock, in cash or in a combination of the two.

If you die before receiving the value of your Account, it will be transferred to your spouse or other beneficiary you have named under the rules of the Plan, provided the proper forms have been filed.

Designation of Beneficiary

When you enroll in the Plan or make a rollover contribution, you should name a beneficiary (someone to receive your benefits from the Plan in the event of your death) by completing a beneficiary designation form and submitting it to Fidelity P.O. Box 770003 Cincinnati, OH 45277-0065.

You may designate anyone as your beneficiary. If you are married, your spouse is automatically your beneficiary unless you designate someone else, in which case your spouse must give his or her consent by signing the beneficiary designation form in the presence of a notary public or a Plan representative.

You may change your beneficiary at any time by submitting a new form. However, if you name someone other than your spouse, your spouse must give his or her consent by signing the beneficiary designation form in the presence of a notary public or a Plan representative.

Payments to your beneficiary, other than your spouse, must begin by December 31st of the calendar year following the calendar year of your death. If your beneficiary is your spouse, payments will begin by the later of (1) December 31 of the calendar year immediately following the calendar year in which you died, and (2) December 31 of the year in which you would have reached age 70-1/2.

Forms of Distribution Options

- Lump Sum
- Installments

Unless you elect otherwise, the balance of your Account invested in the NiSource Stock Fund will be distributed in installments of not more than five years (unless such balance exceeds a certain limit).

If your Account balance is $5,000 or less and no rollover election form has been completed, your Account will automatically be paid to you (or your beneficiary, if applicable) in a lump sum after your termination of employment (or death).

Effective March 28, 2005, if your Account balance is $1,000 or less when you terminate employment, the Company automatically pays you a lump sum. If your Account balance is greater than $1,000 but less than or equal to $5,000 when you terminate employment and no distribution election form has been

completed, the Plan Administrator will roll over your Account balance to an individual retirement plan designated by the Plan Administrator.

TAX IMPLICATIONS OF PARTICIPATION IN THE PLAN

The discussion of Federal income tax consequences that follows is included for general information only and reflects the provisions of the Internal Revenue Code as in effect on January 1, 2004. The discussion does not describe all relevant tax matters (such as state and local income and inheritance taxes and federal estate and gift taxes) that should be considered in connection with participation in the Plan and does not completely describe all provisions associated with the tax matters discussed. Accordingly, you are advised to consult a personal tax adviser for tax planning relevant to the Plan and are further advised not to rely exclusively on the discussion that follows.

Contributions

The Plan is a qualified plan under Sections 401(a), 401(k) and 401(m) of the Internal Revenue Code. As a result, the amount of your Compensation that you elect to defer under the Plan through pre-tax contributions, and the Company matching contributions and rollover contributions, and any earnings thereon, are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts. The amount of your pre-tax contributions will, however, be included in your income in the year in which these amounts are considered earned for purposes of Social Security (FICA) taxes. In addition, some states, cities or counties may impose taxes on your pre-tax contributions.

Although after-tax contributions are deducted from your compensation after all applicable taxes have been withheld, the earnings on such contributions are not subject to federal income taxes until you or your beneficiary withdraws or receives a distribution of these amounts.

Distributions

You generally can roll over a distribution or withdrawal of your Account to an eligible retirement plan of another employer or to an IRA, if the distribution is an "eligible rollover distribution" as defined in the Code. In such event, the amount rolled over and earnings thereon are not subject to income tax until subsequently distributed to you or your beneficiary. Any taxable amount of an eligible rollover distribution that is not rolled over will be subject to a mandatory 20% withholding requirement. See "Income Tax Withholding" below.

An additional 10% excise tax will be imposed on any taxable distribution or withdrawal you receive before you reach age 59-1/2, unless the distribution or withdrawal is (1) rolled over to another eligible retirement plan or to an IRA, (2) made to a beneficiary after your death, (3) made on account of your retirement due to disability, (4) made after separation from service after you attain age 55, (5) made to you for payment of medical expenses that could be deducted on your tax return, (6) paid in equal installments over your life or life expectancy or the lives or life expectancy of you and your beneficiary, or (7) made to an alternate payee pursuant to a qualified domestic relations order.

Note that these rules apply to in-service withdrawals as well as distributions upon termination of employment.

To the extent that you receive shares of NiSource stock, your tax liability is based on the cost to the Plan trust of purchasing the stock for the Company matching contributions to your account. This value is taxed at ordinary income tax rates. Tax on any gain is deferred until you actually sell the stock. At that time, any gain is taxed at the capital gains tax rate.

Lump Sum Distributions

If you receive a lump sum distribution and you were born before January 1, 1936, (1) you can make a one-time election to figure the tax on the distribution by using "10-year averaging" at 1986 rates; and (2) you may elect to have the part of your distribution that is attributable to your pre-1974 participation in the Plan (if any) taxed as long-term capital gain at a rate of 20%. You generally can elect this special tax treatment only once in your lifetime and if you have previously rolled over a payment from the Plan, you cannot use this special tax treatment for later payments from the Plan. You should consult your tax advisers as to your eligibility for and the manner of electing this special treatment.

Special Rules for In-Service Withdrawals of After-Tax Contributions

If you have after-tax contributions held in your Account, a withdrawal of any portion or all of your after-tax contributions and the earnings attributable thereto may be subject to Federal income tax as ordinary income. No portion of any such withdrawal will be subject to Federal tax, however, until the total amounts withdrawn by you after December 31, 1986 exceeds the amount of your After-Tax Contributions made as of December 31, 1986. Thereafter, the amount of any such withdrawal subject to Federal income tax will be determined by multiplying the amount withdrawn by a fraction, the numerator of which is the total amount of the earnings then credited to your after-tax contributions subaccount and the denominator of which is the total value of your after-tax contribution subaccount at the time of such withdrawal.

ROLLOVERS

Most Plan distributions and withdrawals are subject to mandatory Federal income tax withholding. The Trustee is required to withhold 20% of the taxable portion of any "eligible rollover distribution," unless you elect to have the Trustee make a direct rollover of the distribution into another employer's eligible retirement plan that accepts rollovers, or to an IRA. A distribution or withdrawal is not an "eligible rollover distribution" and may not be rolled over, if it is (1) a series of substantially equal period installments over ten years or more, or over your life expectancy or the joint life expectancies of you and your beneficiary, (2) a required distribution due to your attainment of age 70-1/2 (or retirement if later), (3) a hardship distribution or (4) a distribution made to a non-spousal beneficiary.

A taxable distribution or withdrawal that is not an "eligible rollover distribution" is subject to voluntary Federal income tax withholding, which means that you can request that no withholding tax be deducted from your distribution.

Prior to receiving a distribution of any amounts from the Plan, you will receive a Notice of Tax Treatment to assist you in determining your tax liability. The rules governing the Federal income taxation of a distribution are complex and are subject to change, and you should seek the advice of your tax advisers in connection with a distribution from the Plan.

To make a direct rollover, you must contact Fidelity at **1-800-305-401K** (1-800-305-4015). A Fidelity representative will ask you for specific information on the IRA or the other employer's plan to which you are requesting the rollover and let you know if a rollover is available to you.

Situations Affecting Your Plan Benefits

This section describes how the Plan provides you or your beneficiary with benefits. It is important that you understand the conditions under which benefits could be less than expected or not paid at all or limited, including:

- If the investment funds you choose experience losses, the value of your contributions can decrease.

- If you are affected by total annual contribution or compensation limits under the Code, the amounts you and the Company contribute on your behalf may be limited. If you are affected by these limits, you will be notified.

- If the Plan does not pass required nondiscrimination testing, all or a portion of the contributions made on behalf of highly compensated employees may be reduced. Nondiscrimination testing is required by law to ensure a fair mix of contributions from and for employees at all income levels. If you are affected by these limits, you will be notified.

- If you fail to make proper application for benefits or fail to provide necessary information, your benefits could be delayed.

- If you do not keep your most recent address on file and the Company cannot locate you, your benefit payment may be delayed. Once you (or your beneficiary, if you die) provide a current address, benefit payments can be made.

- The IRS sets maximum limits on the amount you can contribute to your Account every year.

- Your Account belongs to you and may not be sold, assigned, transferred, pledged or garnisheed under most circumstances.

However, if required by a Qualified Domestic Relations Order ("QDRO"), all or a portion of your pension benefit maybe assigned to your former spouse or a dependent rather than you or your designated beneficiary to meet payments for child support, alimony or marital property rights. As soon as you are aware of any court proceedings that may affect your Account, contact MySource for Human Resources at **1-888-640-3320**. You and your beneficiaries may obtain, free of charge, a copy of the procedures governing QDROs from the Plan administrator.

- If you (or your beneficiary) are unable to care for your own affairs, any payments due may be directed to someone authorized to conduct your affairs. This may be a relative, a court-appointed guardian or some other person.

Claim Denial and Appeal Process

If your claim for a benefit under the Plan is denied in whole or in part, you (or your beneficiary) will be notified in writing by the Plan administrator within 90 days of the receipt of your claim (180 days if special circumstances apply). This written notice will include:

- The specific reason(s) for the denial;
- References to the Plan provision(s) on which the denial is based;
- A description of any additional material or information that is necessary to complete the claim; and
- The procedures for appealing the decision.

You or your authorized representative may review all documents related to any denial of a benefit. If you disagree with the Plan administrator's decision, you have 60 days from the receipt of the original denial to request a review. This request should be in writing and sent to MySource for Human Resources, which handles the day-to-day administration of the Plan at the following address:

[MySource for Human Resources
2300 Discovery Drive
P.O. Box 785003
Orlando, FL 32878-5003] **[GLORIA TO VERIFY THAT THIS INFORMATION IS CORRECT FOR 401(k) PLANS]**

Your appeal will be reviewed and you will receive written notification of a decision within 60 days. If special circumstances require more time for this process, you will be notified in writing no later than 120 days after the receipt of your request. Again, you will be told why your appeal was denied and which Plan provisions support that decision. All determinations of appeals made by the Plan administrator are final and binding.

Social Security Benefits

In addition to your benefits from the Plan, you can receive benefits from Social Security. Currently, if you were born before 1938, your full Social Security retirement benefits are payable at age 65. If you were born after 1937, your full Social Security benefits will be payable between ages 65 and 67, depending on your year of birth. You may elect to receive Social Security benefits as early as age 62, but the monthly amount will be reduced because you will be expected to receive it over a longer period of time.

Your Social Security benefits are calculated using your earnings subject to Social Security taxes. These taxes are paid equally by you and by the Company. You may go to your local Social Security office for a record of your past wages that were subject to Social Security taxes. You can also request a booklet that explains, in detail, how to determine your Social Security benefits.

Social Security benefits are not paid automatically. You should apply at the Social Security office nearest your home approximately three months before you want your benefits to begin. When you apply, you should bring your own Social Security card or a record of your number, your birth certificate or other evidence of your age, and your W-2 federal income tax statement for the previous year. If you do not have all these documents, do not delay in applying because people in the Social Security office can tell you about other proofs of age and eligibility which can be used instead.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine (without charge) at the Plan administrator's office and at other specified locations—such as work sites and union halls—all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

- Obtain from the Plan Administrator, once a year, a statement of your total benefits accrued and your non-forfeitable (vested) retirement benefits (if any), or the earliest date on which benefits will become non-forfeitable (vested). The Plan may require a written request for this statement, but it must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under the Plan is denied or ignored—in whole or in part—you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials—unless the materials were not sent because of reasons beyond the control of the administrator.

- If you have a claim for benefits that is denied or ignored—in whole or in part—you may file suit in a state or federal court.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a Qualified Domestic Relations Order (QDRO), you may file suit in federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

- If you file suit against the Plan, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees—for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the Employee Benefits Security Administration Brochure Request Line (also called the "Publications Hotline") at **1-800-998-7542**;

- Logging on to the Internet at **www.dol.gov/dol/ebsa;** or

- Contacting the EBSA field office nearest you.

A copy of the Plan document is on file at the NiSource corporate offices, 801 E. 86th Avenue, Merrillville, IN 46410. These documents may be read by you, your beneficiaries or your legal representatives at any reasonable time. Additionally, if you make a written request, you may receive a copy of the Plan document. You may be charged for the copies.

If you have any questions regarding either the Plan or this SPD, you should contact MySource for Human Resources at **1-888-640-3320**.

Additional Information

Dividends

Dividends on the shares of NiSource stock in the NiSource Stock Fund paid to your Account will be used to acquire additional shares of NiSource stock.

Plan Expenses

Administrative expenses of the Plan, including fees of the trustee, counsel, accountants or other experts appointed under the Plan, will be paid out of the trust to the extent not paid by the Company.

Plan Statements

As a Plan participant, you will receive a statement of your Plan Account quarterly from Fidelity that shows your Account balance as of the end of the most recent quarter. You can elect to receive your statement online. You also can view your statement online beginning the day after the end of the quarter and going back for 24 months. Check your statement to be aware of your Account activity. Please contact Fidelity within 60 days of receiving your statement if you think there is an error.

Your Account is valued by Fidelity at the close of every business day. You can call Fidelity at **1-800-305-401K** (1-800-305-4015) or log on to your account at **www.401k.com** seven days a week to review your current Account balance.

If the Plan Ends

The Company reserves the rights to change, suspend, amend or terminate the Plan at any time, in whole or in part, subject to applicable collective bargaining agreements. Generally, Account balances cannot be reduced except for investment losses, even by a Plan amendment. Termination of the Plan is unlikely, but if the Plan is terminated, your Account automatically will remain 100 percent vested. If any material changes are made to the Plan in the future, you will be notified.

Benefits Are Not Insured

The Plan is a defined contribution plan providing specifically defined levels of contributions. This type of plan is not eligible for benefit insurance through the Pension Benefit Guaranty Corporation ("PBGC"), and no particular dollar level of benefits is guaranteed. All of the contributions are deposited with the trustee. All payments of Plan benefits are made from the Plan's trust fund.

No Guarantee

Nothing in this SPD states or implies that participation in the Plan is a guarantee of continued employment with the Company, nor is it a guarantee that contribution levels will remain unchanged in future years.

Limiting Liability

The Plan is intended to meet the provisions of Section 404(c) under ERISA. This means that Plan fiduciaries (those responsible for administering the Plan) may be relieved of liability for losses resulting from a your investment instructions.

As a Plan participant, you may request (and the Plan fiduciary must provide):

- A description of the annual operating expenses of each investment option (e.g., investment management fees, administrative fees and transaction costs) which reduce the rate of return to participants, and the total amount of such expenses expressed as a percentage of the investment option's average net assets.

- Copies of any annual reports, financial statements and reports, and any other materials relating to the investment options available under the Plan, to the extent such information is provided to the Plan.

- A list of the assets in the portfolio of each investment option; the value of each asset (or the proportion of the investment option which it comprises); and the fixed-rate investment contracts, the name of the bank, savings and loan association, or insurance company issuing the contract, the term of the contract and the rate of return of the contract.

- Information concerning the value of shares or units in the available investment options, as well as the past and current investment performance determined, net of expenses, on a reasonable and consistent basis.

- Information concerning the value of shares or units in the investment options held in your Account.

Administrative Information

Plan Administrator

The Plan administrator is the NiSource Inc. and Affiliates Retirement Plan Administrative and Investment Committee. The Plan administrator has the sole authority to interpret the terms of the Plan. You may contact the Plan administrator at:

NiSource Inc.
Attention: NiSource Inc. and Affiliates
Retirement Plan Administrative and Investment Committee
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Employer I.D. Number

The Employer Identification Number ("EIN") assigned by the IRS for Bay State Gas Company is 04-3442797.

Plan Type, Name and Number

The Plan is classified as a defined contribution plan and has been assigned Plan number 011. It also is a Code section 401(k) plan and an ERISA section 404(c) plan. The official Plan name is the Bay State Gas Company Savings Plan for Operating Employees.

Plan Year

The official Plan year is the calendar year, January 1 through December 31.

Plan Trustee

The Plan trustee is responsible for holding the assets of the trust fund according to the participants' and the Company's directions, and for distributing Plan payments. The money in the trust fund is set aside for the exclusive benefit of Plan participants and their beneficiaries.

The trustee for the Plan is:

Fidelity Management Trust Company
82 Devonshire Street
Boston, MA 02109

Agent for Service of Legal Process

The agent for service of legal process is:

NiSource Inc.
Executive Vice President of Human Resources and Communication
801 East 86th Avenue
Merrillville, IN 46410
1-219-647-5600

Legal process may also be served on the Plan administrator or the trustee.

Collective Bargaining Agreement

Your benefits under the Plan are subject to the following collective bargaining agreement:

Union/Local	**Term of Collective Bargaining Agreement**
Lawrence Division, International Brotherhood of Electrical Workers, Local 326; Brockton Division – Operating Employees, Utility Workers' Union of America, AFL-CIO, Local 273; Brockton Division – Clerical/Technical Employees, Utility Workers' Union of America, AFL-CIO, Local 273; Northern Utilities, Inc., Portland Division, Brotherhood of Utility Workers of New England, Incorporated, Local 341; Granite State Gas Transmission, Inc., Brotherhood of Utility Workers of New England, Incorporated, Local 341; Springfield Division, United Steel Workers of America, AFL-CIO, Local 12026; Springfield Division, International Brotherhood of Electrical Workers, Local 486; Northern Utilities, Inc., Portsmouth Division, United Steelworkers of America, AFL-CIO-CIC, Local 12012-6; EnergyUSA Brockton Propane Division, Oil, Chemical and Atomic Workers International Union, AFL-CIO, Quincy Local 8-366; EnergyUSA Northern Propane Division, United Steelworkers of America, AFL-CIO-CLC, Amalgamated Local No. 12012-8; Springfield Division – Clerical/Technical Unit, United Steelworkers of America, AFL-CIO-CLC, Local 12026	**[Ask Gloria]**

Schedule A
Local 326 – Lawrence Employees

Pre-Tax and After-Tax Contributions Eligibility:

First day of the month after you complete a 60-day period of employment.

Eligibility for Company Matching Contribution:

First day of the next month after you complete a period of employment consisting of twelve consecutive months in which you are credited with at least 1,000 hours of service. For each period for which you make pre-tax contributions, the Company will make matching contributions, as described below, on your behalf if you are a member of Local 326 Lawrence Employees and you (a) are not eligible to receive medical insurance coverage upon retirement, or (b) would be otherwise eligible to receive medical coverage upon retirement but you made a one-time irrevocable election to waive your right to receive medical insurance coverage upon your retirement.

Company Matching Contributions:

The Company matching contribution is 50% of your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Schedule B
Local 273 – Brockton Operating Employees

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a period of employment consisting of twelve consecutive months in which you are credited with at least 1,000 hours of service.

Eligibility for Company Matching Contribution:

First day of the next month after you complete a period of employment consisting of twelve consecutive months in which you are credited with at least 1,000 hours of service. For each period for which you make pre-tax contributions, the Company will make matching contributions, as described below, on your behalf if you are a member of Local 273 Brockton Operating Employees and you (a) are not eligible to receive medical insurance coverage upon retirement, or (b) would be otherwise eligible to receive medical coverage upon retirement but you made a one-time irrevocable election to waive your right to receive medical insurance coverage upon your retirement.

Company Matching Contributions:

The Company matching contribution is 50% of your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Schedule C
Local 273 – Brockton Clerical/Technical Employees

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a period of employment consisting of twelve consecutive months in which you are credited with at least 1,000 hours of service

Eligibility for Company Matching Contribution:

First day of the next month after you complete a period of employment consisting of twelve consecutive months in which you are credited with at least 1,000 hours of service. For each period for which you make pre-tax contributions, the Company will make matching contributions, as described below, on your behalf if you are a member of Local 273 Brockton Clerical/Technical Employees and you (a) are not eligible to receive medical insurance coverage upon retirement, or (b) would be otherwise eligible to receive medical coverage upon retirement but you made a one-time irrevocable election to waive your right to receive medical insurance coverage upon your retirement.

Company Matching Contributions:

The Company matching contribution is 100% of your pre-tax contributions each pay period, up to 1% of your compensation for that pay period, and 50% of your pre-tax contributions each pay period on the next 5% of your compensation for that pay period.

Schedule D
Local 341 –Portland Employees

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a 12-month eligibility period in which you are credited with at least 1,000 hours of service

Eligibility for Company Matching Contribution:

First day of the next month after you complete a 12-month eligibility period in which you are credited with at least 1,000 hours of service. For each period for which you make pre-tax contributions, the Company will make matching contributions, as described below, on your behalf if you are a member of Local 341 Portland Employees and you (a) are not eligible to receive medical insurance coverage upon retirement, or (b) would be otherwise eligible to receive medical coverage upon retirement but you made a one-time irrevocable election to waive your right to receive medical insurance coverage upon your retirement.

Company Matching Contributions:

The Company matching contribution is 50% of each your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Schedule E
Local 341 –Granite State Employees

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a 12-month eligibility period in which you are credited with at least 1,000 hours of service.

Eligibility for Company Matching Contribution:

First day of the next month after you complete a 12-month eligibility period in which you are credited with at least 1,000 hours of service. For each period for which you make pre-tax contributions, the Company will make matching contributions, as described below, on your behalf if you are a member of Local 341 Granite State Employees and you (a) are not eligible to receive medical insurance coverage upon retirement, or (b) would be otherwise eligible to receive medical coverage upon retirement but you made a one-time irrevocable election to waive your right to receive medical insurance coverage upon your retirement.

Company Matching Contributions:

The Company matching contribution is 50% of your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Schedule F
Local 12026 Springfield Employees
(Other Than Clerical Technical Unit)

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a 60-day period of employment.

Eligibility for Company Matching Contribution:

First day of the next month after you complete a 12-month eligibility period in which you are credited with at least 1,000 hours of service.

Company Matching Contributions:

The Company matching contribution is 50% of your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Schedule G
Local 486 Springfield Employees

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a 60-day period of employment.

Eligibility for Company Matching Contribution:

First day of the next month after you complete a 12-month eligibility period in which you are credited with at least 1,000 hours of service.

Company Matching Contributions:

The Company matching contribution is 50% of your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Schedule H
Local 12012-6 Portsmouth Employees

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a 60-day period of employment.

Eligibility for Company Matching Contribution:

First day of the next month after you complete a 12-month eligibility period in which you are credited with at least 1,000 hours of service.

Company Matching Contributions:

The Company matching contribution is 50% of your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Schedule K
Local 12026 Springfield Employee-Clerical Technical Unit

Pre-Tax and After-Tax Contributions Eligibility:

First day of the next month after you complete a 60-day period of employment.

Eligibility for Company Matching Contribution:

First day of the next month after you complete a period of employment consisting of twelve consecutive months in which you are credited with at least 1,000 hours of service.

Company Matching Contributions:

The Company matching contribution is 50% of your pre-tax contributions each pay period, up to 5% of your compensation for that pay period.

Notwithstanding the foregoing, if you

(1) became an employee before September 1, 1990 and were under age 45 on January 1, 1992; or

(2) became an employee on or after September 1, 1990; or

(3) became an employee before September 1, 1990, were at least age 45 on January 1, 1992 and irrevocably elected to waive eligibility for post-retiree medical coverage no later than September 1, 1992,

the Company matching contribution is 100% of your pre-tax contributions each pay period, up to 2.5% of your compensation for that pay period, and 50% of your pre-tax contributions each pay period on the next 5% of your compensation for that pay period.

NiSource
Dental Plan

Summary Plan
Description (SPD)

DRAFT DOCUMENT

FOR DISCUSSION

PURPOSES ONLY

Contents

Page

Your Dental Plan Options

The NiSource Dental Plan has two dental coverage options:

- Basic Dental; and
- Dental Plus.

Both Basic Dental and Dental Plus provide the same level of coverage for eligible dental services such as preventive care services, basic services, and major services.

When you use an in-network provider you receive the added benefit of lower, negotiated fees. If you use an out-of-network provider, claims are paid by the Claims Administrator are based on reasonable and customary charges. As a result you are required to pay for any amount your dentist charges over what is reasonable and customary.

To find a provider in your area, log on to the MySource for Human Resource Web site at www.mysourceforhr.com or call the MySource automated telephone system at 1-888-640-3320. Customer service associates can then connect you with a Provider Directly so that you can locate a participating dentist near you.

Highlights of the Dental Plans Coverage

Here is a summary of the benefits under each option.

Feature	Basic Dental (In or Out-of-Network)		Dental Plus	
Annual Deductible	**You Pay**		**You Pay**	
• Covered Member	$50		None	
• Covered Member + Spouse	$100		None	
• Covered Member + Dependent	$100		None	
• Covered Member +Family	$150		None	
Coinsurance	**You Pay**	**Plan Pays**	**You Pay**	**Plan Pays**
• Preventive and Diagnostic Services	Nothing	100%	Nothing	100%
• Basic Services (i.e., fillings, extractions)	20% (after deductible)	80% (after deductible)	20%	80%
• Major Services (i.e., crowns, dentures)	50% (after deductible)	50% (after deductible)	50%	50%
• Orthodontia (adult and child)	100%	Nothing	50%	50%, up to the lifetime maximum
Maximums	**Plan Pays**		**Plan Pays**	
• Annual Maximum	Up to $2,000 per person per year		Up to $2,000 per person per year	
• Orthodontia Lifetime Maximum	Not applicable		Up to $1,500 per person	

All expenses incurred, whether care is received from a dentist in or out-of-network, will be applied toward the calendar year deductible and maximum amounts according to the summary above.

Eligibility

You and your eligible dependents may elect to participate in the Dental Plan ("Plan") if you are actively at work and you fall under one of the categories set forth below.

- A regular full-time employee of a Participating Employer (as defined in the **Overview**) who regularly works 40 or more hours per week; or

- A regular part-time employee of a Participating Employer, who regularly works 10 or more, but less than 40 hours per week

Your eligible dependents include:

- Your lawful spouse, if not legally separated;

- Your child who: (1) is less than 19 years old*; or (2) is 19 years but less than 25 years old and attends an educational institution full-time (i.e. accredited college or university, or a vocational or trade school, that is fully licensed (by the state, if required) or has at least one student who is eligible to receive government-sponsored loans or grants);

- Your child who is incapable of self-sustaining employment due to mental or physical disability if: (1) proof of the child's disability, if requested by the Plan, is received by the Plan within 31 days of the date dependent status would otherwise terminate, (2) the child is dependent upon the employee for financial support and maintenance, (3) the employee continues to be covered by the Plan, and (4) the child's disability continues; and

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient, as having a right to participate in the Plan as a dependent.

If one or more of your covered dependents is a college student (age 19 or up to their 25th birthday), you need to verify that your dependent is a full-time student **each year through MySource at 1-888-640-3320.*

Information regarding eligibility can be access through MySource Web site at www.myshourforhr.com or by calling the MySource automated telephone system at 1-888-640-3320 to speak to a service representative.

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section of this Dental Plan SPD, you and your eligible dependents can participate in the Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire plan year and can only be changed during annual open enrollment. However, if you experience a qualified life event, you may enroll or change existing coverages during the year. (Please see the "*Enrollment*" section of the **Overview** and the "*Changing and Continuing Your Coverages*" section of the **Overview** for further details.)

Opt-Out Credit

If you are eligible for coverage but fail to enroll, you will automatically be covered under the Basic Plan.

If you elect the "No Coverage Option" under the Plan, you may be eligible for an Opt-Out Credit. Please refer to the enrollment material to see if the company is currently offering this option.

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When Coverage Begins and Ends

Coverage Begins

Generally, coverage under the Plan may become effective (i) on your first day of active employment for regular new hires, (ii) on the first day of the following plan year for eligible employees who enroll during the annual enrollment period, or (iii) on the date of the qualified life event for employees who enroll due to such qualified life event. Eligible dependents have the same effective date, if you properly enroll them.

Coverage Ends

The coverage will end on the **last day of the month** in which you and/or your dependent loses eligibility.

Eligibility generally ends on:

- The date as of which the Plan is terminated;
- The date that the Plan is amended to terminate coverage with respect to an employee;
- The date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided in the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;
- The date on which a leave of absence begins, except to the extent continuation coverage is required by the Family Medical Leave Act of 1993; and
- The end of the month following the date an employee terminated employment.

A Dependent shall cease to participate in the Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends;
- The last date for which any required contributions for the dependent's coverage were made; or
- The end of the month following the date the dependent no longer qualifies as a dependent.

Covered Expenses

The Plan pays for certain services and supplies that are considered necessary in terms of generally accepted dental standards, appropriate to properly treat the dental condition, and must be recommended by the participant's dentist.

The Basic Dental coverage option and the Dental Plus coverage option covered expenses include, but may not be limited to, the following eligible dental services and supplies up to the maximum allowance and/or Reasonable and Customary Charge:

Preventive Treatment

Preventive Treatment. Preventive Treatment is treatment designed to prevent dental disease, defect or injury and includes:

- Oral examination;
- Cleaning and scaling of teeth;
- Topical fluoride application of fluoride solutions;
- Bite-wing x-rays
- Dental sealants for Covered Persons under age 20;

- Note: The services described above are each limited to twice in a calendar year but not more than once in any period of 5 consecutive months.
- Full-month series of x-rays once in each period of 36 consecutive months.

Basic Treatment

Basic Treatment is designed to correct dental disease, defect or injury and includes:

- Extractions and alveolectomy at the time of tooth extractions;
- Amalgam, Silicate, acrylic, and composite restorations;
- Dental surgery;
- Diagnostic x-ray and laboratory procedures required in relation to dental surgery;
- General anesthesia required in relations to dental surgery (special rules may apply);

- Treatment for relief of dental pain;
- Drugs and medicines that require a Dentist's written prescription, including the cost of medication and its administration when provided by injection in the Dentist's office;
- Space maintainers for missing primary teeth, and habit-breaking appliances;
- Consultations required by the attending Dentist;
- Relines and rebases to existing dentures;
- Endodontic Treatment;
- Periodontic Treatment; and

Major Treatment

Major Treatment is also designed to correct dental disease, defect or injury and includes:

- Inlays, onlays, filings, and crowns (including precision attachments for dentures).
- Repair of existing dentures;
- Initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth lost or extracted while covered under this Plan;
- First installation (including adjustments during the six-month period following installation) of a removable denture (partial or full) to replace one or more natural teeth extracted while covered under the Plan; and replacement of a removable denture (partial or full), fixed bridgework or crowns, or the addition of teeth, inlays, onlays, crowns or restorations to these appliances, but only if:

  - the covered person has been covered by the Plan for at least 12 months; and the existing appliance was installed at least five years prior to its replacement; and the existing appliance cannot be made serviceable; or

  - the existing appliance was installed while the person was covered by the Plan; and the existing appliance is temporary; and replacement by a permanent appliance is required and made within 12 months from the date the temporary appliance was installed; or

  - the replacement is made necessary by the extraction of functioning natural teeth or accidental injury other than a chewing injury; and the replacement is completed within 12 months of the extraction or accident.

Orthodontia Services

The Plan pays benefits for orthodontia services, provided you select the Dental Plus coverage option. If you select the Basic Dental coverage option, the Plan does not pay benefits for orthodontia services. The Claims Administrator must determine that the service is necessary, and all orthodontia appliances and treatment must be part of a course of orthodontic treatment that begins while your coverage is in effect.

The Plan pays benefits for the following orthodontia services:

- Preliminary studies, including X rays in association with orthodontia treatments are covered under Class IV (Ortho) Benefits.
- Comprehensive full-banded orthodontia treatment (adult or child).
- Appliances for tooth guidance, up to one appliance per covered individual.
- Orthodontic retention appliances, up to one appliance per covered individual.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Expenses Not Covered

The Plan pays benefits for a variety of dental services, provided they are necessary according to generally accepted dental standards, appropriate to properly treat the dental condition, and recommended by your dentist. However, some limits and exclusions do apply.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your health care flexible spending account to pay for eligible dental expenses that aren't covered by the Dental Plan. You also can use the health care flexible spending account to reimburse yourself for your share of the cost of any dental care that you receive (i.e., your 100%, 50%, or 20% coinsurance amounts). You must submit eligible expenses to the health care flexible account by the March 31st following the plan year in which you incur the expense.

The dental expenses **not** covered include, but are not limited to the following: *Please contact the Claims Administrator with questions regarding those Dental Expenses not covered.*

- Charges for dental treatment that is required as the result of war, declared or undeclared;
- Charges resulting from broken appointments or the completion of claim forms;
- Charges for appliances that have been lost, mislaid or stolen;
- Charges for dental treatments or procedures that:
  - are cosmetic in nature;
  - do not have general professional endorsement; or
  - are experimental or investigational in nature according to the American Dental Association;
- Charges for dental treatment or services that consist of:
  - correction of any birth defect or developmental malformation that does not interfere with function;
  - Dietary planning for the control of dental caries; or
  - Oral hygiene instructions;
- Charges related to initial installation of full or partial dentures or bridgework, including abutments, when they are installed to replace natural teeth extracted before the date on which the Covered Person became covered under the Plan;

- Charges for customized procedures, such as:
  - Implants – except for charges not exceeding $600;
  - Precision or semi-precision attachments;
  - Over dentures or customized prosthesis;
  - Duplicate sets of dentures; or
  - Facings on crowns or pontics and molars;
- Charges for crowns for teeth that are restorable by other means or for the purpose of periodontal splinting;
- Charges for expenses that are incurred:
  - Before the effective date of coverage under the Plan;
  - After the date on which the coverage under the Plan terminates; or
  - For covered dental treatment that is completed after the date on which coverage under the Plan terminates;
- Charges that are part of the charge for any procedure that is in excess of the charge for the least costly procedure that will, as determined by the Claims Administrator, as applicable, produce a professionally satisfactory result;
- Charges for non-surgical dental treatment for Temporomandibular Dysfunction (TMJ), except for a lifetime maximum benefit of $300 for one appliance;
- Charges not specified in this Plan as covered;
- Charges for services and supplies not prescribed or approved by a Dentist or Physician;
- Charges exceeding the Reasonable and Customary amount or are not Medically Necessary;
- Charges paid or payable under any Worker's Compensation law, Occupational Disease law or similar law;
- Charges for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;

- Charges for services provided by the Covered Person's parent, spouse, brother, sister, son or daughter;
- Except as otherwise provided, expenses paid or payable under any other dental plan contributed to by the Company;
- Charges for which claims are not filed on a timely basis in accordance with Plan provisions;
- Charges for legal expenses, whether or not incurred to obtain dental treatment;
- Charges for any prosthetic dental devices finally installed more than 90 days after coverage under the Plan ends;
- Charges for myofunctional therapy, bite registration, bite analysis, or athletic mouth guards;
- Charges that are not necessary for the care and treatment of the teeth;
- Charges received for dentures involving specialized techniques;
- Charges related to services provided by the United State government, any state government, or any government outside the United States in which the participant or dependent is entitled to receive benefits. An exception to this exclusion applies for services provided by the United States government that can be billed to the Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985;
- Charges that a covered person is not legally required to pay and charges that would not have been made if the Plan had not existed;
- Charges that are reimbursed, or that could be reimbursed, by any public program;
- Dental work required as a result of accidental injury to natural teeth and for certain oral surgery procedures such as;
    - Excision of tooth root without tooth extractions; and
    - Incision or excision of gums or tissues if not in connection with tooth repair.

Any expense that your or your covered dependent incur to the extent that benefits are paid or are payable under the mandatory part of any auto insurance policy that is written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. The Claims Administrator takes into account any adjustment option that you or your covered dependent chooses under such part.

Coordination of Benefits (COB)

If you or your dependents have dental coverage under another dental plan, this Plan coordinates benefits with the other benefits to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits*" section of the **Overview** to learn more about the Plan's COB features.

Filing A Claim

General

Generally, dentists file claims electronically on your behalf provided that the dentist is a participating dentist. If you see a non-participating dentist, you may need to file your own claim. Claims should be submitted to the Claims Administrator.

How to File Claims

If you file your own claim form, follow these steps.

- Complete your portion of the claim form (your form will include step-by-step instructions for completing the correct information). Your dentist will need to complete his or her portion of the form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator online via the MySource for Human Resources Web site (www.mysourceforhr.com)..

- Attach copies of all available dental bills that should be considered for Plan benefits. These bills should include:

    - Name of patient;
    - Name and Social Security number of employee;
    - Date of treatment;
    - Type of treatment;
    - Charge for the treatment;
    - Provider of the treatment; and
    - Any other information that clearly indicates the dental expense.

- Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

    CIGNA
    PO Box 188036
    Chattanooga, TN 37422-8036

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Claim Denial and Appeal Process

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator decides your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15–day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim improperly, you will receive a notice of the improper filing and how to correct it within five days after the pre-service claim is received. Once you receive notice, you then have 45 days to provide any needed information. If you receive a denial notice the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Outline the claims appeals process.

Post-Service Claims

If you submit a post-service claim you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all the necessary information). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you are notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information. If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Outline the claims appeals process.

Urgent-Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain.

You will receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator takes into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If You Have Questions
If you have a question or concern regarding a benefit determination, contact the claims administrator or the MySource Participant Advocacy service through the MySource for Human Resources toll-free number (1-888-640-3320) before you request a formal appeal. If you are not satisfied with a benefit determination, you can appeal it.

If you file an urgent care claim improperly, you receive a notice of the improper filing and how to correct it within 24 hours after the Claims Administrator receives the urgent–care claim. Once you receive this notice you then have 48 hours to provide the requested information. You receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Plan receives the requested information; or
- The end of the period that you have to provide the specified additional information.

If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;

- Refer you to the part of the Plan upon which the denial is based; and
- Outline the claims appeals process.

Concurrent-Care Claims

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request meets that of an urgent care claim (as defined above), the Claims Administrator decides your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment does not involve urgent care, the Claims Administrator treats your claim as either a pre-service or post-service claim (as applicable and considers the claim according to the post-service or pre-service time frames; whichever applies.

Appeal to Claims Administrator

If your initial claim is denied in whole or in part (as described above), you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the claim denial notification.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of you request for review.

Post- Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Denies A Claim on Appeal

If the Claims Administrator denies your claim on appeal, it will notify you of the following, in a manner to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and

- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Second Appeal to the Plan Administrator for Pre and Post Service Claims

If the Claims Administrator denies all or any portion of your pre or post service claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator by sending a written request for review to the Plan Administrator within 180 days of your receipt of the Claims Administrator's notice of claim denial.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal.

If the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional that has appropriate training and experience in

the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Plan Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Plan Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Plan Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Plan Administrator Denies Your Claim on Appeal

If the Plan Administrator denies your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If the Plan Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Plan Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of

the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Continuation of Coverage and COBRA Coverage

Continuation of Coverage

Generally, the Dental Coverage is only available to you if you are actively at work. However, there are certain leaves during which you can continue your coverage. They are:

Short Term Disability Leave – Dental coverage for you and your eligible dependents continue while you are receiving STD benefits or if an appeal is pending in accordance with the provisions of the STD Plan. Your premium contributions for the dental coverage will continue to be deducted from your check.

Long Term Disability Leave – Dental coverage for you and your eligible dependents continue while you are receiving LTD benefits or if an appeal is pending in accordance with the provisions of the LTD Plan. You must continue to make your required contribution.

Family Medical Leave (FMLA) – Dental coverage for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family Medical Leave Act (FMLA). In the event you are on FMLA leave, you must continue to make your required contribution for the Dental coverage.

The Company may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) – If you are absent from employment because of service in the "uniformed services" (as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")), you may elect to continue coverage under the Plan during the period of your service to the extent provided in USERRA and the NiSource Military Leave of Absence Policy.

COBRA Coverage

In the event your benefits under the Plan terminate, you may be eligible to continue your dental coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") provided you experience a COBRA qualifying event. Please see the "*Continuation of Benefits (COBRA)*" section of the **Overview** for further details.

Contact Information

Specific coverage related questions should be directed to MySource for Human Resources either by going to their Web site or using their automated telephone system.

Dental Plan Coverage	
Basic Dental and Dental Plus	CIGNA Dental www.mysourceforhr.com (link to www.cigna.com) 1-888-640-3320 (MySource for Human Resources) The *Claims Administrator* can be reached by phone via the MySource for Human Resources automated telephone system

General Plan Information

The Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974).

Plan Type:	Dental
Plan Number:	507
Claims Administrator:	CIGNA P.O. Box 188036 Chattanooga, TN 37422-8036 www.cigna.com
Type of Insurance:	Self – Funded.
Contribution Source:	Employee and Employer

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NiSource Flexible Benefits Plan

Flexible Spending Accounts (FSAs)

Summary Plan Description (SPD)

DRAFT DOCUMENT
FOR DISCUSSION
PURPOSES ONLY

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Your Flexible Spending Accounts (FSAs)

NiSource Inc. (the "Company") provides eligible employees with the option to participate in a Flexible Spending Account Plan (the "FSA Plan" or "Plan"). The FSA Plan has two different flexible spending accounts. They are:

- The Health Care FSA; and
- The Dependent Care FSA.

You may participate in one or both of these accounts. The contributions you make to the FSA accounts are not subject to Federal, and in many cases, state and local income tax, which reduces your taxable income.

The Health Care FSA allows you to set aside before-tax money from your paychecks to pay for certain eligible health care expenses that are not covered by the Medical, Dental or Vision Plans. You may set aside up to $5,000 a year (deducted from your pay in equal installments throughout the year) to pay for eligible out-of-pocket expenses such as deductibles, co-payments, or expenses that the plan limits or excludes.

The Dependent Care FSA works similarly to the Health Care FSA. However, the before-tax money that you can set aside can only be used for reimbursement for dependent care expenses for eligible dependents. You may set aside up to $5,000 per year; or $2,500 if you are married and file separate federal income tax returns.

For purposes of the Dependent Care FSA, eligible dependents include:

- Children age 13 and under who live with you and for whom you are entitled to a personal tax exemption;
- Spouse who is physically or mentally incapable of caring for himself or herself;
- Other dependents of any age, who are incapable of self-care, provided the dependent spends at least eight hours per day in your household. These other dependents may include children, grandchildren, siblings, parents, or any other person who lives in your household.

Example: To show how you might use your dependent care FSA to reimburse this particular expense, let's assume that your five-year-old child attends kindergarten in the morning primarily for educational purposes. In the afternoon, he attends an after-school day care program at the same school. Your total cost for sending him to the school is $3,000 ($1,800 is for the after-school program). Only the $1,800 expense is considered eligible for reimbursement from the dependent care FSA.

The IRS strictly regulates the administration of these accounts:

- In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire plan year. However, if there is a "qualified life event" (i.e. marriage, birth, adoption, coverage change), you may enroll or change existing coverages during the year. Please refer to the "*Changing and Continuing Your Coverages*" section of the **Overview** for further details.

- Eligible expenses must be incurred prior to the end of the year (December 31st) in order to receive reimbursement.

- If you do not use all the money that you have funded into your accounts, the IRS requires that you forfeit the remaining funds.

- You cannot receive a refund; carry balances over to the next year or transfer money from one account to another.

Highlights of The Flexible Spending Accounts (FSAs)

FSA Features	Eligible Dependents	Eligible Expenses
Health Care		
Before Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000	The FSA can be used to reimburse eligible out-of-pocket expenses incurred by you, your eligible spouse, or anyone you claim as a dependent on your federal income tax return.	Certain medical, dental, and vision expenses not covered under the Medical, Dental, or Vision Plans such as deductibles, co-payments and coinsurance amounts. The expense must be considered a "Medical Expense" as defined in the Internal Revenue Code. *A list of eligible expenses can be found later in this section.*
Dependent Care		
Before Tax Contributions Minimum Annual Contribution is $60 Maximum Annual Contribution is $5,000; $2,500 if you are married and file separate federal income tax returns.	For purposes of the dependent care spending account, eligible dependents are: • Your children age 13 and under whom live with you and for whom you are entitled to a personal tax exemption. • Your spouse who is physically or mentally incapable of caring for himself or herself. • Your dependents (as defined by the IRS) of any age that are incapable of self-care, including parents, provided the dependent spends at least eight hours per day in your household.	Expenses you incur to care for your child or a dependent family member while at work. If you are married, your spouse also must work, be looking for work, be a full-time student for at least five months during the calendar year, or be physically or mentally unable to care for your dependent(s). *A list of eligible expenses can be found later in this section.*

Eligibility

You can elect to participate in the FSA Plan provided you are actively at work and fall under one of the categories set forth below.

- A regular full-time non-union employee of the Company or Participating Employer, as defined in the Overview section of this Handbook**,** who regularly works 40 or more hours per week.

- A regular part-time non-union employee of the Company or Participating Employer who regularly works ten or more, but less than 40, hours per week.

- A regular full-time union employee of the Company or Participating Employer who regularly works 40 or more hours per week, who collective bargaining agreement provides for his or her eligibility in the Plan.

- A regular part-time union employee of the Company or Participating Employer who regularly works ten or more, but less than 40, hours per week, and the collective bargaining agreement provides for his or her eligibility in the Plan.

Enrollment

Provided eligibility requirements are met, as described in the "*Eligibility*" section of this FSA Plan SPD, you can participate in the FSA Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire plan year. In addition, participation in the FSA Plan requires annual enrollment at which time you must elect the amount that you want to contribute to the FSA Plan for the year. If there is a qualified life event, you may enroll or change existing coverages during the year. (Please see the "*Enrollment*" section of the **Overview** section of this Handbook and the "*Changing and Continuing Your Coverages*" subsection of the **Overview** section of this Handbook for further details).

If you are eligible to participate but do enroll in the FSA Plan, you will not be able to participate in the FSA Plan during the plan year.

When Coverage Begins and Ends

Coverage Begins

Generally, participation in the FSA Plan may begin, if you properly enroll, (i) on your first day of active employment for a regular new hire, (ii) on the first day of the following plan year for eligible employees who enroll during the annual enrollment period, or (iii) for eligible employees who enroll due to a qualified life event, on the date the Plan approves their enrollment or change, which will generally coincide with the date of the qualified life event.

Coverage Ends

Participation under the FSA Plan terminates as follows:

- the date on which the Plan terminates;
- the date on which an employee ceases to be an employee for any reason; or
- with respect to a dependent, the date on which the dependent ceases to be a dependent.

Health Care Eligible Expenses

Health care expenses that are eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Expenses covered by an employer-sponsored health care plan, but not reimbursed due to a deductible or co-payment.
- Prescription vision expenses (including eyewear, contacts and optometrist), contact lens solution, a guide dog for the blind and special education devices for the blind (such as a special typewriter).
- Expenses that may not be covered by an employer-sponsored health care plan, including (but not limited to):
    - Confinement to a facility primarily for screening tests and physical therapy or hydrotherapy;
    - Cosmetic surgery if it is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease;
    - Services for chromosome or fertility studies;
    - Treatment (other than surgery, which is covered by the Medical Plan) of corns, bunions, calluses, foot structural disorders, etc;
    - Services related to sexual transformation or sexual dysfunctions or inadequacies;
    - Ace bandages, support hose, or other pressure garments prescribed by a physician;
    - Charges for medical expenses in excess of reasonable and customary expenses;
    - Acupuncture for pain relief as performed by a licensed practitioner;
    - Prescription or non-prescription drugs and medicines used for medical care;
    - Orthodontic services not covered by a health care plan;
    - Transportation expense to receive medical care, including fares for public transportation and actual out-of-pocket car expense, such as gas and oil. In lieu of out-of-pocket expenses, a standard mileage rate of 10 cents per mile (plus tolls and parking) may be used;

- Hearing expenses including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf;

- Hypnosis for treatment of an illness;

- "Halfway house" care to help individuals adjust from life in a mental hospital to community living;

- Tutoring by a licensed therapist for a child with a severe learning disability and special schooling for handicapped individuals;

- Lifetime care advance payment to a private institution for lifetime care, treatment, or training of a mentally or physically handicapped patient;

- Medical information plan fees paid to a plan maintaining an individual's medical information by computer;

- Special car controls for the handicapped; and

- Full or partial reimbursement for certain capital expenditures that are primarily made for health care reasons (e.g., an air conditioner installed in the home of a person with severe allergies may qualify for partial reimbursement, and an exercise swimming pool to aid in the recovery of a stroke victim may qualify for reimbursement).

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Health Care Expenses Not Eligible

The health care expenses that are **not** eligible for reimbursement from the Health Care FSA include, but may not be limited to the following:

- Marriage or family counseling;
- The salary expense of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn (even though such care may be required due to the death of the mother in childbirth);
- Funeral and burial expenses;
- Household and domestic help (even though recommended by a qualified physician due to your or dependent's inability to perform physical housework);
- Custodial care in an institution;
- Costs for sending a "problem child" to a special school for benefits the child may receive from a special course of study and disciplinary methods;
- Health club dues, YMCA dues, steam bath, etc;
- Social activities, such as dance lessons or classes (even if recommended by a qualified physician for general health improvement);
- Membership fees or costs associated with weight loss or smoking cessation programs for general health and well-being purposes;
- Maternity clothes, diaper services, etc;
- Cosmetics, toiletries, toothpaste, etc;
- General health care aids purchased without a prescription, such as dietary supplements (e.g., vitamins);
- Premiums for other group or individual insurance coverage;
- The segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving your care;
- Vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect;

- Retin-A when used solely for cosmetic purposes;
- Herbs (even if they are used to treat an illness or injury); and
- Premiums for contact lens replacement insurance.

Filing a Claim

Health Care FSA Reimbursement

If your health-related expenses are eligible for reimbursement from the Program's Medical, Dental, or Vision Plans (or another medical, dental, or vision plan outside the Program), those expenses should be submitted to that plan first. After a payment determination is made, the unreimbursed expenses can then be submitted to your Health Care FSA.

The total annual amount that you can elect to contribute to the Health Care FSA (less any previous reimbursements) is available for reimbursement (regardless of the amount that you have contributed to your FSA to-date). Contributions then continue to be deducted from your paychecks until your annual goal amount is reached.

You have until March 31st of the following calendar year to submit claims for expenses you incur between January 1 and December 31 of the previous year.

Remember: Any funds that remain in the FSAs after March 31st is forfeited.

A form can be obtained online via the MySource for Human Resources Web site (www.mysourceforhr.com), or call the Claims Administrator via the MySource for Human Resources toll-free number 1-888-640-3320 to request a form.

Completed forms should be submitted along with the following documentation.

- **The Explanation of Benefits (EOB):** The EOB from the Claims Administrator indicates what expenses were covered by your medical/dental/vision plans. If you have another benefit plan available to you, you must submit your EOB with your completed health care reimbursement form.

- **A Copay Receipt:** This receipt is from the provider, and may be the only documentation if the copay is the only expense.

- **An Itemized Bill or Statement:** This is from the provider, and shows what expenses are not covered by the medical/dental/vision plan. It may include the:

    - Name and address of the service provider;

    - Dates of service (not the billing date or the paid date);

    - Dollar amount charged;

    - Patient's name; and

    - Description or type of services rendered.

Please note that canceled checks and balance-forward statements are not acceptable documentation for reimbursement.

Submit the completed form and documentation to (address is also noted on the form):

Claims Administrator
P.O. Box 14053
Lexington, KY 40511
Be sure to retain copies. Reimbursement request information cannot be returned.

Dependent Care Eligible Expenses

The dependent care expenses that are eligible for reimbursement from the Dependent Care FSA include, but may not be limited to:

- Family day care providers;
- Babysitter;
- Caregivers for a disabled dependent or spouse who resides in the participant's home;
- Housekeeper, maid or cook, provided the services are attributable in part to the care of an eligible dependent);
- Dependent care provided outside your home by an eligible care provider, including care provided in a neighbor's home or in an approved nursery school or dependent day care center (provided the dependent regularly spends at least eight hours a day in your home). For example, day care centers for children and disabled adults qualify, but 24-hour nursing care facilities do not. Also, facilities that care for seven or more nonresident individuals must comply with all applicable state and local regulations governing day care centers;
- Payments for before- and after-school care for eligible children from kindergarten up to and including age 12;
- Payments in lieu of regular dependent day care to summer day camp or other summer programs (but not overnight camp);
- Certain expenses for children not yet in the first grade, for example:
    - Nursery school;
    - Pre-school; and
    - Kindergarten tuition (kindergarten expenses qualify for reimbursement from the Dependent Care FSA only if the expense is primarily for custodial care and not education).

To confirm if an expense is eligible, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Dependent Care Expenses Not Eligible

The dependent care expenses that are not eligible for reimbursement from the Dependent Care FSA include, but may not be limited to the following:

- Dependent care expenses that you incur before (or after) their participation in the dependent care FSA begins (or ends);
- Any expense that you claim for the dependent care tax credit on your federal income tax return, or any expense that is paid by any other similar reimbursement-type plan or program;
- Any expenses that are reimbursed by your health care FSA;
- Expenses for the education of a qualified dependent;
- Expenses paid for food and clothing;

- Dependent care provided by a family member who is under age 19 at the end of the taxable year, or by another dependent for whom you claim as a dependent exemption on your tax return;
- Expenses for health care;
- Tuition for kindergarten children, and all educational expenses for first grade or higher;
- Housekeeping expenses that are not related to dependent care, or payments for services while you are at home from work because of an illness;
- Child or dependent care provided while:
    - You are at work and your spouse is doing volunteer work, even if a nominal fee is paid (or vice versa);
    - You and your spouse are doing volunteer work (even if a nominal fee is paid); or
    - You and your spouse is not working (such as weekend or evening babysitting fees);
- Expenses for food, clothing, health care, or entertainment of a qualified dependent;
- Transportation expenses to and from the dependent care location;
- Expenses for overnight camps;
- Services of a gardener or chauffeur; and
- Care provided by a round-the-clock nursing home.

Dependent Care FSA Reimbursements

For Dependent Care FSA reimbursements, only the current balance in your FSA is available for reimbursement. This means that you are reimbursed up to the amount that you have actually set aside from each paycheck up to that point (less any previous reimbursements). So, if the reimbursement request that you submit exceeds the amount currently in your Dependent Care FSA, you are reimbursed for the remainder, after you contribute more money to your Dependent Care FSA via future paychecks.

To obtain reimbursement for an expense, complete and submit a dependent care reimbursement form. A form can be obtained online via the MySource for Human Resources Web site (www.mysourceforhr.com), or by calling the Claims Administrator via the MySource for Human Resources toll-free number 1-888-640-3320 to request a form.

Submit the completed form along with the following documentation.

- **Provider's Bill or Itemized Receipt.** The provider must sign this documentation, and it must itemize the date(s) of service as well as the amount(s) charged.

  Canceled checks are not considered acceptable documentation.

- **Dependent Care Provider's Name, Address, and Social Security Number (or Federal Tax Identification Number).** For tax-reporting purposes, you must include the provider's name and his or her Social Security number (or taxpayer identification number). The taxpayer identification number is not necessary if the provider is a nonprofit, religious, charitable, or educational organization.

Submit the completed form and documentation to (address is also noted on the form):

Claims Administrator
P.O. Box 14053
Lexington, KY 40511
Be sure to retain copies. Reimbursement request information cannot be returned.

Filing Deadline

You may submit a health care or dependent care reimbursement form at any time after you incur an eligible health and/or dependent care expense (provided you meet the minimum expense requirement). You have until March 31st of the following calendar year to submit claims for expenses you incur between January 1 and December 31 of the previous year. In other words, if you incur an expense in 2004, you have until March 31, 2005 to submit a request for reimbursement. Expenses are considered "incurred" on the date the service was rendered (not when it is billed or charged, or when you actually pays for the service).

Remember: Funds that remain in the FSAs after March 31st will be forfeited

Claim Denial and Appeal Process

The Health Care FSA

The type of claim that is made determines the time frame under which the Claims Administrator makes a determination regarding a claim. The Company delegates the authority to decide claims and appeals under the Health Care FSA to the Claims Administrator. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If a pre-service claim is properly submitted with all necessary information, the Claims Administrator decides the claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If a pre-service claim is filed improperly, you will receive a notice of the improper filing and how to correct it within five days after your pre-service claim is received. Once you receive notice, you will then have a designated amount of time (at least 45 days) to provide any needed information.

If you receive a denial notice, the notice:

- Explains the reasons for the denial;
- Describes any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- References to the part of the Plan upon which the denial is based; and
- Outlines the claims appeals process.

Post-Service Claims

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you are notified within the 30-day period and the notice will specify the required information. Once you receive notice, you will then have a designated amount of time (at least 45 days) to provide any needed information. If you receive a denial notice, the notice:

- Explains the reasons for the denial;
- Describes any additional material or information necessary for them to complete your claim and explains why the material or information is necessary;
- References the part of the Plan upon which the denial is based; and
- Outlines the claims appeals process.

Urgent-Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain.

You will receive a notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator takes into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent-care claim improperly, you will receive a notice of the improper filing and how to correct it within 24 hours after the Claims Administrator receives your urgent–care claim. Once you receive this notice, you will then have 48 hours to provide the requested information.

You will receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

Questions regarding a benefit determination should be directed to the claims administrator or the MySource Participant Advocacy service through the MySource for Human Resources toll-free number (1-888-640-3320) before a request for a formal appeal. .

- The day the Plan receives the requested information; or
- The end of the period that you have to provide the specified additional information.

If an you receive a denial notice, the notice:

- Explains the reasons for the denial;
- Describes any additional material or information necessary for them to complete your claim and explains why the material or information is necessary;
- References the part of the Plan upon which the denial is based; and
- Outlines the claims appeals process.

Concurrent-Care Claims

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request meets that of an urgent care claim (as defined in this main section), the Claims Administrator decides your request within 24 hours after you receive your request. You must make your request at least 24 hours before the end of your approved treatment.

If you request to extend ongoing treatment does not involve urgent care, the Claims Administrator treats the claim as either a pre-service or post-service claim (as applicable and considers the claim according to the post-service or pre-service time frames; whichever applies.

Appeal to Claims Administrator

If your initial claim is denied in whole or in part, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the claim denial notification.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by your or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of the your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of their determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of your request for review.

Post- Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of their determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of their determination of review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Denies A Claim on Appeal

If the Claims Administrator denies your claim on appeal, they will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator by sending a written request for review to the Plan Administrator within 180 days of their receipt of the Claims Administrator's notice of claim denial.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. The letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal.

If the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Plan Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with their adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of their determination of review within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of your request for review.

Post- Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of their determination of review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of their determination of review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Plan Administrator Denies A Claim on Appeal

If the Plan Administrator denies your claim on appeal, they will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process. If the Plan Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to the you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Plan Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

The Dependent Care FSA

Consideration of Initial Claim

Within 90 days of receiving the claim, the Claims Administrator will provide you (or your beneficiary) with a written notice of its decision. If because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating (i) the specific reason or reasons for the denial; (ii) reference to the specific plan provisions on which the denial is based; (iii) a description of any additional material or information necessary for them to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Claims Administrator

If your claim is denied in whole or in part, you have the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial.

Upon receipt of your letter, your claim will be reviewed. You will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written claim is received). The Claims Administrator will provide you with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension.

If the Claims Administrator denies your claim in whole or in part, you will be provided with written notice of the denial stating (i) the specific reason or reasons for the denial; (ii) reference to the specific plan provisions on which the denial is based; (iii) a description of any additional material or information necessary for them to perfect the claim and an explanation of why such material or information is necessary; and (iv) a description of the plan's review procedures (as set forth below) and the time limits applicable to such procedures.

Appeal to Plan Administrator

If the Claims Administrator denies all or any portion of your claim on appeal, you may file a written claim with the Plan Administrator within 60 days after your appeal has been denied in whole, or in part, by the Claims Administrator.

Any claim for benefits with the Plan Administrator will be processed within 60 days of its receipt unless additional time is required to process the claim, in which event you will be notified that an additional period of 60 days is required to process the claim.

If your claim for benefits is denied in whole or part by the Plan Administrator, written notice of the decision to deny such application will be promptly furnished to you within 60 days after receipt of the claim for benefits, or within 120 days of receipt of such claim if the Plan Administrator gives notice in writing that an extension of time is required for processing the claim. Each notice of denial of an application shall be in writing and shall contain the following information: (i) the specific reason or reasons for the denial; (ii) specific reference to the plan provisions upon which the denial is based; (iii) a description of any additional material or information necessary for the applicant to perfect the application and an explanation of why such material or information is necessary; and (iv) an explanation of the plan's review procedures (as described below).

Second Appeal to the Plan Administrator

In the event the Plan Administrator upholds the claim denial in whole or in part, you or your duly authorized representative may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by you or your duly authorized representative, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Plan Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event you shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, you or your duly authorized representative may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and you or your duly authorized representative shall be in writing unless you or your duly authorized representative requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include (i) the specific reason or reasons for the decision; (ii) specific reference to the plan provisions upon which the decision is based; and (iii) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.

Continuation of Coverage and COBRA Coverage

Continuation of Coverage

Generally, participation in the Flexible Spending Accounts is only available to you if you are actively at work. However, there are certain leaves during which you can continue your participation in the FSA Plan. They are:

Short Term Disability ("STD") Leave – You can continue to participate in the Health Care FSA. Your contributions are deducted from your benefit check.

You **cannot** make any contributions to the Dependent Care FSA while you are receiving STD benefits. However, you may use the existing balance in you account to pay for any eligible expense you incur before your disability began.

Long Term Disability ("LTD") Leave – You **cannot** continue to participate in the Health Care and/or Dependent Care FSA while you are receiving LTD Plan benefits. You may, however, use the existing balance in your account to pay for any eligible expense you incur before your LTD benefits payment began. If you return to work, your original contribution election is reamortized over the remaining pay periods for the calendar plan year.

Family Medical Leave (FMLA) – You **cannot** continue to participate in the Health Care and/or Dependent Care FSA on a pre-tax basis while on a FMLA leave. You may, however, use the existing balance in your account to pay for any eligible expenses that you incur prior to your last day worked before your FMLA leave. You have the option to continue to participate in the Healthcare FSA during your FMLA leave on an after-tax basis through COBRA.

COBRA Coverage

In the event your benefits under the FSA Plan terminate, you may continue to make current contributions to the Health Care FSA for the remainder of the plan year under COBRA. Your contributions, however, would be on an after-tax basis. You cannot continue participation in the Dependent Care FSA.

If you elect to continue participation in the Plan until the end of the year, your deductions and reimbursement schedule would remain the same. However, if you elect not to continue making current contributions to the Plan, you may only submit eligible expenses for the expenses you incurred prior to the day your participation ended.

The COBRA administrator will send information about continuing participation in the Health Care FSA. Please refer to the "*Continuation of Benefits (COBRA)*" section of the **Overview** for further details.

Contact Information

Specific coverage related questions should be directed to MySource for Human Resources by going to their Web site or using their automated telephone system.

The Flexible Spending Accounts Health Care and Dependent Care	FlexBenCorporation www.mysourceforhr.com (link to www.flexben.com) 1-888-640-3320 (MySource for Human Resources) The *Claims Administrator* can be contacted by phone via the MySource for Human Resources automated telephone system

General Plan Information

The Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974).

Plan Type:	Section 125
Plan Numbers:	
Health Care Flexible Spending Account	511
Dependent Care Flexible Spending Account	512
Claims Administrator/Insurer:	FlexBen Corporation 2250 Butterfield Drive, Suite 100 Troy, MI 48084 www.flexben.com
Type of Coverage:	Not Applicable
Contribution Source:	Employee pre-tax

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NiSource Consolidated Flex Medical Plan

Summary Plan Description (SPD)

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Your Medical Plan Options

NiSource Inc. (the "Company") provides eligible employees and their dependents with the following medical coverage options provided by BlueCross BlueShield Network (administered by Anthem Insurance):

- The Preferred Provider Organization (PPO), which uses the BlueCross/BlueShield Network;
- The Standard Plan 1 (traditional indemnity coverage); and
- The Standard Plan 2 (catastrophic indemnity coverage).

Keep in mind that the Plan covers expenses based on reasonable and customary charges. R&C charges are those charges that a provider typically charges in his or her area for the same or similar service or supply. Charges above the R&C charges are not paid by the Plan.

The Medical Plan ("Plan") may also offer Health Maintenance Organizations (HMOs)—provided you live in an area where an HMO option is available. *If this option is available to you, you will be provided with a separate HMO SPD. Please refer to that document for further information regarding HMO coverage.*

The PPO option includes a network of qualified health care providers who offer discounted services for being able to participate in the network. You may also use out-of-network providers and still receive a benefit; however, your costs may be higher if you choose out-of-network services.

To find a provider who participates in the network, log on to the MySource for Human Resources Web site at www.mysourceforhr.com or call MySource at 1-888-640-3320 to request assistance.

The Standard Plans 1 and 2 do not require you to receive services from a particular provider.

Prescription Drugs

With any of the above-mentioned medical options, except if you are an HMO participant, you and your dependents are eligible for prescription drug coverage offered through *Walgreens HealthCare Plus.*

Your prescription drug coverage offers you access to a network of participating retail pharmacies for most of your short-term medications through *Walgreens HealthCare Plus... (The pharmacies that participate in this network are not limited to Walgreens pharmacies.)* You also have access to a mail order service for long-term or maintenance medications.

If you select the HMO medical coverage, you have prescription drug coverage through your HMO. Please refer to the HMO SPD for details regarding your prescription drug coverage.

Mental Health/Substance Abuse Treatments

When you elect coverage under the PPO, Standard Plan 1, or Standard Plan 2 coverage options, you also receive coverage for mental health and substance abuse treatments. For the Plan to pay benefits, *Value Options* (the "Claims Administrator") must coordinate your care.

Through *Value Options*, you have access to a network of participating mental health and substance abuse professionals, including psychiatrists, psychologists and Master's level therapists who specialize in such treatment. Please note: the network of providers available through Value Options is not the same network of providers available through BlueCross/Blue Shield.

Highlights of the Medical Plans

The Plan offers a PPO, two indemnity coverages (traditional and catastrophic indemnity), and HMOs. Your personalized enrollment worksheet indicates which coverage option(s) are available to you. Below is a summary of the deductibles, copays, coinsurance amounts, and calendar year out-of-pocket maximums for the PPO, Standard 1 and Standard 2 coverage options. *Please refer to the HMO SPD for further information regarding the HMO medical coverage.*

Deductible, Calendar Year Out-of-Pocket Maximum, and Maximum Benefits

Feature	PPO		Standard Plan 1 (Traditional Indemnity)	Standard Plan 2 (Catastrophic Indemnity)
	In Network (Or Out-of-Area)	Out of Network		
Calendar Year Deductible	**You Pay**	**You Pay**	**You Pay**	**You Pay**
• Covered Member	$300	$500	$500	$1,000
• Covered Member + Spouse	$600	$1,000	$1,000	$2,000
• Covered Member + child(ren)	$600	$1,000	$1,000	$2,000
• Covered Member + Family (spouse + children)	$900	$1,500	$1,500	$3,000
Copay Requirement	$15	Not Applicable	$15 (wellness only)	$15 (wellness only)
Calendar Year Out-of-Pocket Maximum (does not include deductible)	**You Pay**	**You Pay**	**You Pay**	**You Pay**
• Covered Member	$700	$1,600	$1,500	$3,000
• Covered Member + 1	$1,400	$3,200	$3,000	$6,000
• Covered Member + Family	$2,100	$4,800	$4,500	$9,000

Feature	PPO		Standard Plan 1 (Traditional Indemnity)	Standard Plan 2 (Catastrophic Indemnity)
	In Network	Out of Network		
• Lifetime Maximum	$2,000,000 (combined in-network and out of network)		$2,000,000	$2,000,000
• Temporomandibular Joint Dysfunction and Related Medical Disorders	The plan limits benefits to surgery and appliances only	The plan limits benefits to surgery and appliances only	The plan limits benefits to surgery and appliances only	The plan limits benefits to surgery and appliances only
• Routine hearing exams and aids	One exam and one aid per ear during a two calendar-year period	One exam and one aid per ear during a two calendar-year period	One exam and one aid per ear during a two calendar-year period	One exam and one aid per ear during a two calendar-year period
• Rehabilitation (Inpatient Physical Medicine/Rehab (PMR))	60 days per calendar year	60 days per calendar year	60 days per calendar year	60 days per calendar year
• Outpatient Physical, Occupational, or Speech Therapy	26 visits per calendar year	26 visits per calendar year	26 visits per calendar year	26 visits per calendar year
• Chiropractic/Spinal Manipulation Services	26 visits per calendar year	26 visits per calendar year	26 visits per calendar year	26 visits per calendar year
• Wellness Benefits				
◦ Adult Preventive Care Services	$250 per covered person per year (excludes allergy tests and treatments)	$250 per covered person per year (excludes allergy tests and treatments)	$250 per covered person per year (excludes allergy tests and treatments)	$250 per covered person per year (excludes allergy tests and treatments)
◦ Well-Baby/ Child Preventive Care Services	$250 per covered person per year	$250 per covered person per year	$250 per covered person per year	$250 per covered person per year
• Home Health Care	No limits (in-network only)	30 visits per calendar year	120 visits	120 visits
• Hospice Care	180 days	180 days	180 days	180 days
• Routine vision exams and hardware	First pair of lenses following cataract surgery only (otherwise, not covered)	First pair of lenses following cataract surgery (otherwise, not covered)	First pair of lenses following cataract surgery (otherwise, not covered)	First pair of lenses following cataract surgery (otherwise, not covered)

Maximum Benefits for Mental Health and Substance Abuse Treatments

Feature	PPO	Standard Plan 1 (Traditional Indemnity)	Standard Plan 2 (Catastrophic Indemnity)
• Mental Health	**In Network (Plan Pays Up To)**	**Out of Network (Plan Pays Up To)**	
• Inpatient	Not Applicable	45 days per year	
• Outpatient	Not Applicable	25 visits per year	
• Substance Abuse			
• Detox Inpatient	Not Applicable	30 days per year	
• Detox Outpatient	Not Applicable	25 visits per year	
• Rehab Inpatient	Not Applicable	30 days per year	
• Rehab Outpatient	Not Applicable	25 visits per year	

Visits for mental health and substance abuse treatments are counted separately to determine applicable co-payments. The number of visits is combined when determining the maximum number of visits for out-of-network care.

Services Provided

The following is a brief summary of the services that the Plan covers for the PPO, Standard Plan 1, and Standard Plan 2 coverage options. *Please refer to the HMO SPD for further information regarding services provided under the HMO plan.*

Type of Service	PPO In Network	PPO Out of Network	Standard Plan 1 (Traditional)	Standard Plan 2 (Catastrophic)
	Plan Pays	**Plan Pays**	**Plan Pays**	**Plan Pays**
Inpatient Services				
• Room and Board and Ancillary Services	85% (after deductible)	65% (after deductible)	75% (after deductible)	75% (after deductible)
• Surgery	85%	65% (after deductible)	75%	75% (after deductible)
• Skilled Nursing Facility	85%	65%	75% (after deductible)	75% (after deductible)
• Physician Services (Including General Nursing Care)	85% (after deductible)	65% (after deductible)	75% (after deductible)	75% (after deductible)
• Pre-admission Testing	85%	65% (after deductible)	75% (after deductible)	75% (after deductible)
Outpatient Services				
• Surgery	85% (85% after copay if surgery is performed in an office setting)	65% (after deductible)	75%	75% (after deductible)
• Dental/ Oral Surgery	85%	65% (after deductible)	75%	75% (after deductible)

Type of Service	PPO In Network	PPO Out of Network	Standard Plan 1 (Traditional)	Standard Plan 2 (Catastrophic)
	Plan Pays	**Plan Pays**	**Plan Pays**	**Plan Pays**
Outpatient Services (Cont'd)				
• TMJ Services	85%	65% (after deductible)	75% (after deductible)	75% (after deductible)
• Second Surgical Opinions	100% (after $15 copay per office visit)	65% (after deductible)	75% (no deductible)	75% (after deductible)
Professional Services (Outpatient)	100%, after $15 copay per office visit (copay does not apply for allergy injections, serums and testing)	65% (after deductible)	75%, after deductible (100% after deductible for allergy injections, serums, and testing)	75%, after deductible (100% after deductible for allergy injections, serums, and testing)
Emergency Care Services				
• Accident	100% (no copay or deductible)	100% (no copay or deductible)	100% (no deductible)	100% (no deductible)
• Medical Emergency	85% (after deductible)	85% (after deductible)	75% (after deductible)	75% (after deductible)
• Non-Medical Emergency	85% (after deductible)	85% (after deductible)	75% (after deductible)	75% (after deductible)
• Urgent Care	100% (after copay)	85% (after deductible)	75% (after deductible)	75% after deductible)
• Ambulance	**80%** (after deductible)	80% (after in-network deductible)	75% (after deductible)	75% (after deductible)
Rehab Services				
• Inpatient Therapy	85%	65% (after deductible)	75%	75% (after deductible)
• Outpatient Therapy	100% (after $15 copay per office visit)	65% (after deductible)	75%	75% (after deductible)
Diagnostic and Laboratory Services				
• Inpatient	85%	65% (after deductible)	75% (no deductible)	75% (after deductible)
• Outpatient	85% (100% if office or independent lab	65% (after deductible)	75% (no deductible)	75% (after deductible)

	independent lab services, copay is applied on the same day)			
Wellness Care	100% (after $15 copay per office visit)	100% (after $15 copay per office visit)	100% after $15 copay per office visit (no deductible)	100% after $15 copay per office visit (no deductible)
Maternity and Infertility				
• Pre-natal Office Visits	100% (after copay)	65% (after deductible)	75% (no deductible)	75% (after deductible)
• Hospital Maternity Care	85%	65% (after deductible)	75% (no deductible)	75% (after deductible)
• Services to Diagnose Infertility	85% (after copay)	65% (after deductible)	75% (after deductible)	75% (after deductible)
Other Covered Services	85%, after deductible (80%, after deductible for durable medical equipment, prosthetics/ orthotics, and first pair of lenses after cataract surgery)	65%, after deductible (80% after deductible for durable medical equipment, prosthetics/ orthotics, and first pair of lenses after cataract surgery)	75% (after deductible)	75% (after deductible)

Mental Health and Substance Abuse

	In Network Plan Pays	Out of Network Plan Pays
Mental Health and Substance Abuse		
• Mental Health Inpatient	85%	65% (after deductible)
• Mental Health Outpatient	**Visits 1 – 6 (EAP):** 100% (If you do not contact the EAP before your first visit, a $15 copay applies) **Visits 7 – 20:** 100% (after $15 copay) **Visits 21 +:** 100% (after $25 copay)	65% (after deductible)
• Substance Abuse (Detox Inpatient)	85%	65% (after deductible)
• Substance Abuse (Detox Outpatient)	**Visits 1 – 6 (EAP):** 100% (If you do not contact the EAP before your first visit, a $15 copay applies) **Visits 7 – 20:** 100% (after $15 copay) **Visits 21 +:** 100% (after $25 copay)	65% (after deductible)
• Substance Abuse (Rehab Inpatient)	85%	65% (after deductible)
• Substance Abuse (Rehab Outpatient)	**Visits 1 – 6 (EAP):** 100% (If you do not contact the EAP before your first visit, a $15 copay applies) **Visits 7 – 20:** 100% (after $15 copay) **Visits 21 +:** 100% (after $25 copay)	65% (after deductible)

The Plan pays benefits for eligible expenses based on the R&C charges that a provider typically charges in the area. The Plan does not pay benefits for any expense that is above the R&C rate. As a result you are responsible for any charges that exceed the R&C rate.

Highlights of Your Prescription Drug Coverage

Here is a brief summary of your prescription drug coverage if you select medical coverage under the PPO, Standard Plan 1 (traditional indemnity), or Standard Plan 2 (catastrophic indemnity) coverage option. *If you select coverage under an HMO, prescription drug services are covered under the HMO plan. Please refer to the HMO SPD for further information regarding that prescription drug coverage.*

Drug Category	Retail Pharmacy You Pay	Retail Pharmacy Plan Pays	Mail Order You Pay	Mail Order Plan Pays
Generic	20% for the cost of drug subject to minimum co-pay of $5 and maximum co-pay of $15	80% after co-pay	$10 co-pay	100% after co-pay
Formulary	20% for the cost of drug subject to minimum co-pay of $15 and maximum co-pay of $45	80% after co-pay	$30 co-pay	100% after co-pay
Non-Formulary	20% for the cost of drug subject to minimum co-pay of $30 and maximum co-pay of $90	80% after co-pay	$60 co-pay	100% after co-pay

Out-of-Pocket Maximum		
The Maximum Amount You Have to Pay Out of Your Pocket Each Year	$750 per person per year	
Day Supply Limit		
The Maximum Amount You Can Receive per Prescribed Order	30-day supply	90-day supply
Refill Limit		
The Maximum Amount You Can Receive per Refill Order	Up to a 30-day supply	Up to a 90-day supply
When to Use		
Use For:	Short-term medications or immediate prescription drug needs	Long-term, maintenance, and injectable medications

*You either pays a percentage of the drug's cost (coinsurance), or a set copay amount (not both). If your percentage of the cost results in an amount that is **less than** the "minimum copay," you pay the minimum copay amount. If your percentage of the cost results in an amount that is **greater than** the "maximum copay," you pay up to the maximum copay amount.

Walgreens Advantage 90 Program

The Walgreens Advantage 90 program allows you to purchase a 90-day supply of drugs in a retail setting. You pay 20% of the cost of a 3-month supply of the drug with the applicable minimums and maximums of 3-times retail copays.

Eligibility

You and your eligible dependents may elect to participate in the Plan if you are actively at work and you fall under one of the categories set forth below:

- A regular full-time employee of a Participating Employer (as defined in the **Overview**) who regularly works 40 or more hours per week
- A regular part-time employee of a Participating Employer, who regularly works 10 or more, but less than 40 hours per week
- A temporary employee of a Participating Employer, who has completed 90 days of continuous, active employment

Your eligible dependents include:

- Your lawful spouse, if you are not legally separated
- Your child who: (1) is less than 19 years old*; or (2) is 19 years but less than 25 years old and attends an educational institution full – time (i.e. accredited college or university, or a vocational or trade school, that is fully licensed (by the state, if required) or has at least one student who is eligible to receive government-sponsored loans or grants); Your child who is incapable of self - sustaining employment due to mental or physical disability if: (1) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise terminate, (2) the child is dependent upon the employee for financial support and maintenance, (3) the employee continues to be covered by the Plan, and (4) the child's disability continues
- Your child who is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient, as having a right to participate in the Plan as a dependent

If one or more of your covered dependents is a college student (age 19 or up to their 25th birthday), you need to verify that your dependent is a full-time student **each year through MySource at 1-888-640-3320.*

Please reference the MySource Web site at www.mysourceforhr.com, or call the MySource automated telephone system at 1-888-640-3320 if you are unsure of whether you are eligible to participate in the Plan.

Enrollment

Provided you meet the eligibility requirements, as described in the "*Eligibility*" section of this Medical Plan SPD, you and your eligible dependents can participate in the Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire plan year and can only be changed during annual open enrollment. However, if you experience a qualified life event, you may enroll or change existing coverages during the year. (Please see the "*Enrollment*" and the "*Changing and Continuing Your Coverages*" section of the **Overview** for further details.)

Opt-Out Credit

If you are eligible for coverage but fail to enroll, you will automatically be covered under Standard Plan 2.

If you elect the "No Coverage Option" under the Plan, you may be eligible for an Opt-Out Credit. Please refer to your enrollment material to see if the company is currently offering this option.

ID Card

If you elect coverage, you will receive an Anthem ID card and a WHI Prescription Drug ID card in the mail shortly after you enroll. The cards should be presented to your provider at the time of service. If additional cards are needed or an ID card is lost, please contact MySource for Human Resources at 1-888-640-3320.

When Coverage Begins and Ends

Coverage Begins

Generally, coverage under the Plan may become effective (i) on your first day of active employment for regular new hires, (ii) on the date immediately following 90 days of continuous active employment for temporary employees, (iii) on the first day of the following plan year for eligible employees who enroll during the annual enrollment period, or (iv) on the date of the qualified life event for employees who enroll due to such qualified life event. Eligible dependents have the same effective date provided you properly enroll them.

Coverage Ends

The coverages will end on the **last day of the month** in which you and/or your dependent loses eligibility.

Your eligibility generally ends:

- The date as of which the Plan is terminated
- The date that the Plan is amended to terminate coverage with respect to an employee
- The date an employee is no longer eligible for coverage under the Plan
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided in the NiSource Military Leave of Absence Policy
- The last date for which any required contribution was made
- The date on which a leave of absence begins, except to the extent continuation coverage is required by the Family Medical Leave Act of 1993
- The end of the month following the date an employee terminated employment

A dependent shall cease to participate in the Plan on the earliest of the following dates:

- The date as of which the Plan is terminated
- The date the employee's coverage ends
- The last date for which any required contributions for the dependent's coverage was made
- The end of the month following the date a dependent no longer qualifies as a dependent

Medical Coverage for Retirees

You are eligible for Medical Benefits as a retired employee if you retire with at least ten years of service and you are at least 55 years of age at the time of your retirement. .

You must notify the company of your planned retirement at which time you will receive further information regarding your retiree benefits. Generally, if you are under age 65, you are eligible to elect the same Medical options that are available to active employees. If you or your spouse is over age 65, there are different plans that are available to you and your spouse. For further information about your benefit or to notify the company of your retirement, contact MySource at 1-888-640-3320.

Utilization Review Program

The Utilization Review (UR) Program is designed to help you determine the course of treatment that will maximize your plan benefits regardless of which coverage option you select (PPO, Standard Plan 1, or Standard Plan 2).

The UR Program offers the following services:

- Pre-admission authorization
- Pre Certification

- Urgent Hospital Admission
- Continued Stay Review
- Other Required Pre-certifications
- Penalty for Non-Compliance
-

The Utilization Review Program provides pre-authorization services to help verify the need for recommended treatment. This service also can propose treatment alternatives that may be more appropriate and cost-effective. Pre-authorization does not guarantee benefits. Benefit availability is subject to eligibility and other terms, conditions, limitations, and exclusions of the plan.

You must contact Anthem (who provides the Utilization Review services) to receive pre-authorization any time your doctor recommends treatment that requires pre-authorization as outlined below:

- **Pre-Admission/Pre-Certification:** Except in the case of an Urgent Hospitalization, all hospitalizations shall be pre-certified prior to admission for any reason. The Pre-certification Provider's name and telephone number shall be provided to each participant. Hospital admission pre-certification shall not guarantee benefits under the Plan. Actual benefits provided under the Plan are determined based on the provisions of the Plan.

- **Pre-Certification Procedure:** When a Physician recommends a non-Urgent Hospitalized, the Participant or such Physician shall call the Pre-certification Provider. The Participant shall advise the Physician of the Plan's pre-admission certification requirement and provide such Physician with adequate information to obtain the pre-certification. The Participant or Physician should secure pre-certification as soon as possible and before a Covered person actually enters the hospital. It shall be the Participant's responsibility to see that the Pre-certification Provider is notified.

- **Urgent Hospital Admission:** In the case of an Urgent Hospitalization, the Covered Person's Physician, the Hospital, or a family member shall telephone the Pre-certification Provider within 48 hours of admission on the first business day following weekend or holiday admissions. The Participant shall provide the Pre-certification Provider with the information required by the Pre-certification Provider.

- **Continued Stay Review**: The Pre-certification Provider may monitor all Hospital stays through contact with the Covered Person's Physician.

- **Other Required Pre-certifications**: The Participant or Participant's Physician shall notify the Pre-certification Provider prior to the provision of the following additional services or supplies: (i) inpatient Surgery, (ii) a Newborn Child Hospital stay beyond that of the mother; (iii) plastic reconstructive surgery; and (iv) durable medical equipment/prosthetics. With approval of the Plan, the Pre-certification Provider may require pre-certification for other services or supplies in accordance with reasonable procedures.

- **Penalty for Non-compliance**: If a Participant fails to comply with the requirements as described above, the Plan may assess a $300 penalty.

There are separate pre-authorization requirements for Mental Health and Substance abuse. Please see *"How Your Mental Health Coverage Works"* for further details.

How Your Prescription Drug Coverage Works

Regardless of whether you participate in the PPO, Standard Plan 1, or Standard Plan 2 coverage options under the Plan, you are also provided with prescription drug coverage through Walgreens Health Initiatives. HMO's offer their own prescription drug coverage.

Your benefits will vary depending on the type of prescription drug you take (generic, formulary or non-formulary) and how you buy it (at the pharmacy or through the mail).

- Generic - Drugs are no longer covered by the original patent. They include the same active ingredients as the brand-name drug at a fraction of the cost.

- Formulary - A list of approved drugs covered under the prescription drug plan. Drugs are selected for the formulary based on a combination of features, including safety, effectiveness and cost. You will pay less for a formulary drug than for a non-formulary drug.

- Non-formulary – Drugs not chosen for the formulary because there are less expensive drugs that effectively provide the same treatment. You may choose drugs not on the formulary, but you will pay more for a non-formulary drug than for a generic or formulary drug.

You can fill your prescription at any participating pharmacy, which includes Walgreens and other chains, and independent pharmacies.

Retail

If you fill your prescription at a retail pharmacy, you need to meet a copay requirement. If your share of the drug's cost is less than the "minimum copay," you pay the minimum copay amount. If your share of the drug's cost is greater than the "maximum copay," you pay up to the maximum copay amount. See the "*Highlights of Your Prescription Drug Coverage*" section of this Medical Plan SPD for further details on plan benefits.

If you fill your prescription at a nonparticipating pharmacy, the Plan pays the cost of the drug less the co-pay. The copay requirement applies to each original prescription or refill. If your physician authorizes a prescription refill, you must bring the prescription bottle or package to the participating pharmacy.

Advantage 90 Program

You may also fill your prescription under the Advantage 90 Program which allows you to purchase a 90 day supply of drugs in a retail setting only from a Walgreens pharmacy (network pharmacies other than a Walgreens store do no participate in this Program). With this program you pay 20% of the cost of a three-month supply of the drug with the applicable minimum and maximums of two times retail copays.

Mail Order Service

If you use the mail order service, complete a Mail Order Form for your first mail service order and submit the appropriate co-payment requirement. The Plan then mails you your long-term medication. See the "*Highlights of Your Prescription Drug Coverage*" section of this Medical Plan SPD for further details on plan benefits.

To find out if your pharmacy is in the Walgreens Network, call MySource for Human Resources automated telephone system at 1-888-640-3320 and select the appropriate option. Or you can log on to the MySource for Human Resources Web site to be linked to Walgreens HealthCare Plus web site.

How to Use Participating Retail Pharmacies

When you or your covered dependent need a prescription filled, simply take it to a participating retail pharmacy. To find out if your pharmacy is in the Walgreens Network, call MySource for Human Resources automated telephone system at 1-888-640-3320.Present your prescription and your WHI Prescription ID card to the pharmacist.

- Make sure that your pharmacist has complete and correct information about you and your covered dependents.
- Pay your applicable share of the cost or

  20% of the prescription drug cost subject to the minimum or maximum co-pay amount.
- Sign for and receive your prescription.

As long as you go to a participating pharmacy and pay the required copay amount, you do not have to file a claim for the Plan to pay benefits.

How to Use the Advantage 90 Program

You and your covered dependents may also have your prescription filled for a 90-day supply at a retail pharmacy through the Advantage 90 Program. The prescription must be filled at a Walgreens Pharmacy store. Although other pharmacies are part of the WHI network, only a Walgreens store can be used under this Program.

Present your prescription and your WHI Prescription ID card to the pharmacist.

- Make sure that your pharmacist has complete and correct information about you and your covered dependents.
- Pay your applicable share of the cost or

  20% of the prescription drug cost subject to the minimum or maximum co-pay amount.

  - Sign for and receive your prescription

How to Use the Mail Order Service

If you or your covered dependents use long-term medications, you can receive up to a 90-day supply of certain covered medications through Walgreens HealthCare Plus mail order service. . With the mail order service, you must submit your prescription and applicable co-pay amount through the mail. . The amount you pay depends on whether you receive a generic, formulary brand, or non-formulary brand drug.

To use the Mail Order Service:

1. Complete the Mail Service Pharmacy Order Form. (A new order form and envelope also is then sent to you with each delivery).

2. Attach the prescription and a check in the amount of the applicable co-pay. Make your check payable to ***Walgreens Healthcare Plus*** or provide a credit card number (follow the instructions on the form). Please do not submit cash with your order.

3. Mail the Prescription Order Form and your check to:

Walgreens Healthcare Plus
7357 Greenbriar Parkway
Orlando FL, 32819-8917

Have your physician write a new original prescription so that you can submit it directly to the mail order service pharmacy with your Mail Service Pharmacy Order Form. If you need medication immediately, ask your doctor for two prescriptions:

- One for an immediate supply (you can then take this to your local participating pharmacy)

- A second one for the extended supply (you can then submit this one to the mail order service)

You will receive your mail order prescription approximately 14 days from the date your mail order is received.

How Your Mental Health/Substance Abuse Coverage Works

Regardless of whether you participate in the PPO, Standard Plan 1, or Standard Plan 2, you are also provided with the following 1) Mental Health and Substance Abuse Coverage, 2) Employee Assistance Program (EAP)/Work Life benefits. These benefits are administered through Value Options. Please refer to the "*Highlights of Your Mental Health and Substance Abuse"* section of this Medical SPD for further details of the Plan coverage. For further information on the EAP/Work Life Benefit, please refer to the "Additional Benefits" section of this Handbook.

Similar to the way you (or your provider) must notify Anthem to receive pre-authorization of inpatient admissions and certain other procedures, you must pre-certify your treatments with Value Options. . This is to ensure that you receive the most appropriate care for your situation. To do so, you must call Value Options at 1-888-640-3320. If you care is not pre-authorized, the Plan will not cover any of the expenses. If you have coverage through an HMO carrier, they provide their coverage.

Medical Expenses Covered

The Plan pays benefits for you (or your covered dependent) for medically necessary eligible expenses up to the maximum allowance. *For services covered under an HMO plan, please refer to the HMO SPD.*

The covered expenses under the medical plan include, but may not be limited to the following:

Inpatient Services

The Plan pays benefits for the following inpatient hospital/medical services and supplies.

- Hospital facility services – such as inpatient room and board – when you are in:
  - A semi-private room
  - A private room (the plan limits benefits to the hospital's prevailing semi-private room rate)
  - An intensive care unit

The Plan pays benefits for both day and nighttime care.

- Inpatient ancillary services and supplies, including:
  - Operating room charges
  - X-rays
  - Laboratory work
  - Surgical dressing
  - Prescribed medications (outpatient prescription drug services are covered under the prescription drug program, see the sections of this Handbook relating to *Prescription Drugs* for details)
- Inpatient surgical services, including:
  - Surgeon's fees when related to the surgical procedure (assistant surgeon's charges may be covered provided they are medically necessary but may not exceed 20% of the primary surgeon's charge)
  - Surgery for morbid obesity

- The Plan does not pay benefits for surgical-related expenses associated with Norplant and IUDs, elective abortions, or reverse sterilization

- Skilled nursing facility care, up to the hospital's prevailing semi-private room rate, including:
  - Bed, board, and general nursing care, and
  - Ancillary services (such as drugs, surgical dressings, or supplies)

The Plan pays benefits provided you receive skilled nursing facility care within 14 days after your hospital confinement. (Your hospital confinement must be at least three consecutive days for the same illness.) In addition, your physician must visit you in the skilled nursing facility at

least once during each 30-day period. The Plan does not pay benefits for custodial care, or for services received in an uncertified skilled nursing facility.

- General nursing care provided by an RN or LPN when you are in:
  - A semi-private room
  - A private room
  - An intensive care unit

- Pre-admission testing, x-rays, or laboratory services performed before inpatient surgery. These tests are considered part of your inpatient hospital surgical stay and are performed on an outpatient basis. The Plan pays benefits provided you would have otherwise been eligible to receive such tests as a hospital inpatient. The Plan does not pay benefits for pre-admission testing if you decide to postpone your surgery.

Outpatient Services

The Plan pays benefits for the following services, provided you receive them on an outpatient basis.

- Hospital facility services and ancillary charges for services performed on an outpatient basis.

- Outpatient surgery and related surgical services when performed in an office setting, including:
  - Any related diagnostic services received on the same day as the outpatient surgery
  - Surgeon's fees when related to the surgical procedure (assistant surgeon's charges may be covered provided they are medically necessary but may not exceed 20% of the primary surgeon's charge), and
  - Surgery for morbid obesity

  The Plan does not pay benefits for outpatient surgical-related expenses associated with Norplant and IUDs, elective abortions**,** or reverse sterilization.

- Dental/oral surgical services, only when required because of an accidental injury to natural teeth (within 36 months of injury). The Plan pays benefits for outpatient facility charges only if your medical condition or the dental procedure requires a hospital setting to ensure your safety. The Plan pays benefits related to the following outpatient oral surgical procedures:
  - The removal of foreign body from the throat, cheek, or tongue;
  - Excision of non-dental lesions from the cheek, tongue, floor and roof of mouth (with or without plastic repair);
  - Repair of fractures or dislocations of facial and jaw bones (but not of alveolar processes);
  - Arthrotomy, arthrectomy, and arthroplasty of temporomandibular joints;
  - Surgical repair or reconstruction of lips due to other than dental causes;
  - Removal of non-dental cysts of the mouth;
  - Operations that involve the salivary, parotid, submaxillary glands, and ducts;

- Operations that involve infraorbital and mandibular nerves;
- Operations that involve the tongue;
- Palatoplasty for cleft palate;
- Operations through the mouth involving sinuses;
- Gingivectomy;
- Any cutting procedure in the mouth (except when performed in connection with the removal of non-impacted teeth, replacement of teeth, dentures or appliances, orthodontia or periodontia, alveoplasty, or the repair or preparation of the mouth to receive or maintain dentures).

The Plan does not pay benefits for dental implants.

- Temporomandibular joint dysfunction and related medical disorders. The Plan limits benefits to:
  - Surgery, provided the surgical procedure is medically appropriate, and
  - Appliances (the Plan pays benefits for appliances just like any other durable medical equipment).

- A second surgical opinion and additional required testing at your request or when recommended by the Utilization Review (UR) Program. The Plan pays benefits provided your physician (other than the one who offers the second opinion) performs the eventual surgery. The Plan pays 100% for any additional surgical opinion consultation and related diagnostic service. If you feel additional consultations are needed, the Plan pays additional benefits at the 100% level (provided you meet any necessary copay or deductible requirement).

Professional Services (Outpatient)

The Plan pays benefits for care you receive from a physician or other specified professional provider (i.e., a general practitioner, family practitioner, a physician of internal medicine, pediatrician, gynecologist, nurse practitioner, or physician assistant), on an outpatient basis.

- Office visits, visits to a clinic, or a physician's visit to your home as part of home care services. You must meet the copay requirement before the Plan pays benefits.

- Services provided by a professional, including:
  - Allergy injections, shots, serums, and immunizations;
  - Diagnostic allergy testing;
  - Routine hearing exams and hearing aids. The Plan limits benefits to one hearing exam and one hearing aid per ear during a two calendar-year period. These services do not apply to the lifetime maximum, and;
  - Services provided by a physical, speech, or occupational therapist.

- Diabetes management services, including:
  - Educational services;
  - Eye exams;

- Diabetic supplies (diabetic supplies are covered under the prescription drug coverage).

The Plan does not pay benefits for professional services when related to Depo-Provera injections or routine vision exams.

Emergency Care Services

The Plan pays benefits for the cost of the following emergency care services:

- Hospital emergency room care when care is associated with:
  - An accident;
  - A medical emergency;
  - A non-medical emergency

- Urgent care

- Ambulance services (local ground or air transportation), when medically necessary to transport you to the nearest appropriately equipped facility that is able to provide necessary treatment. The Plan pays benefits for air-ambulance services only if medically necessary. When ambulance services are used because they are more convenient than other types of transportation, the Plan does not pay benefits.

If your condition is life threatening and you receive emergency care at a hospital outside the network because it is not possible to safely transfer you to a hospital within the network, the Plan still pays benefits at the in-network level.

Rehabilitation Services

The Plan pays benefits for the following inpatient and outpatient rehabilitation services. In some instances, the Plan may extend the limits based on medical necessity.

- Inpatient therapy provided while you are in the hospital, including:
  - Physical Medicine/Rehabilitation (PMR);
  - Cardiac rehabilitation;
  - Chemotherapy;
  - Radiation therapy;
  - Respiratory therapy (including respiratory therapy devices);
  - Infusion;
  - Renal dialysis treatments

- Outpatient therapy treatments, including:
  - Physical therapy (therapy is subject to significant improvement through relatively short-term therapy);
  - Occupational therapy;
  - Speech therapy, provided therapy is restorative in nature or rehabilitative treatment is needed for speech loss or impairment due to an illness or surgery on

account of an illness (other than a functional nervous disorder). If speech loss is due to a congenital anomaly for which corrective surgery has been performed, the corrective surgery must be performed before the therapy and therapy must be designed to provide significant improvement on a relatively short-term basis.

The Plan pays benefits provided a registered professional physical or occupational therapist, or speech therapist certified by the American Speech and Hearing Association renders the appropriate services under the supervision of a physician.

- Chiropractic and spinal manipulation therapy provided a licensed chiropractor performs the services on an outpatient basis. The Plan limits benefits for chiropractic services regardless of medical necessity;

- Physiotherapy provided a licensed physiotherapist performs the services and he or she does not normally live with you or is not related to you or your spouse by blood, marriage, or legal adoption.

Diagnostic and Laboratory Services

The Plan pays benefits for the following diagnostic and laboratory services.

- Inpatient radiology and laboratory services

- Outpatient radiology, diagnostic, and laboratory services performed when you are an outpatient and the services are related to the surgery or medical care, including:
  - X-rays;
  - Radium treatments;
  - Microscopic tests;
  - Laboratory tests and exams

Wellness (Hospital and Professional Services)

The Plan pays benefits for certain preventive-care services. The plan limits benefits for these services.

- Adult wellness care services, including:
  - Routine physical exams and check-ups (including a routine hearing exam and annual diabetes eye exam);
  - Immunizations (including Hepatitis B inoculations);
  - Routine pap smears;
  - Routine prostate-specific antigen tests (PSAs);
  - Routine mammograms;
  - Routine colorectal cancer screenings;
  - Diabetic education training;
  - All additional routine labs and x-rays associated with routine office visits

- Well-child/baby care services, including:

- Well-baby doctor offices visits;
- Routine physical exams and check-ups;
- Immunizations for children;
- All additional routine labs and x-rays associated with routine office visits

Maternity and Infertility

The Plan pays benefits for the following pre-natal, maternity, and infertility-related services. The plan does not pay maternity benefits for your dependent children.

- Pre-natal office visits, including one routine ultrasound;

- Hospital maternity care related to a normal pregnancy and complications of pregnancy, including (one deductible applies to both mother and child's maternity expenses):
  - Inpatient care;
  - Obstetrician services;
  - Routine inpatient nursery charges (unlimited newborn visits);
  - Inpatient pediatrician visits;
  - Birthing center expenses

The Plan pays maternity benefits for your services as well as certain services provided to your newborn infant (even if you initially have employee only coverage). However, if your newborn requires treatment for an illness or injury, the Plan pays benefits for that care only if you add the newborn to coverage. To add your newborn to your coverage, you must call MySource for Human Resources, or log on to the MySource for Human Resources Web site and add your newborn within 31 days of the actual birth. Coverage for the newborn takes effect as of the date of birth.

- Services performed to diagnose infertility. The Plan does not pay benefits for the *treatment of infertility* (i.e., artificial insemination, in-vitro fertilization, embryo transfer, etc.)

Other Covered Services

- Biologicals (for example, injectables and chemotherapy);

- Blood and blood components;

- Durable medical equipment and supplies, including:
  - The rental of wheel chairs, and hospital beds;
  - The rental of iron lungs and other mechanical equipment to treat respiratory paralysis;
  - The rental of equipment for the administration of oxygen;
  - Internal cardiac valves;
  - Internal pacemakers;
  - Mandibular reconstruction devices (not primarily used to support dental prosthesis);

- Bone screws, bolts, nails, plates, and any other internal and permanent devices that are reasonably approved by the Claims Administrator

The Plan pays benefits for the rental or purchase of durable medical equipment at the Claims Administrator's determination. The durable medical equipment or supply must be primarily and customarily used to serve a medical purpose and be required for temporary therapeutic use (benefits are limited to the total cost of the equipment).

- Elective vasectomies and tubal ligations;

- Extended care facility (convalescent care), as approved through the Claims Administrator;

- Home health care services. The Plan pays benefits as long as home health care is medically necessary, it begins within seven days of a hospital discharge, and the care is necessary for the same or a related condition as the hospital stay. The Plan pays benefits for the following home health care services:
  - Nursing services;
  - Therapist services;
  - Home IV infusion;
  - Home health aid services;
  - Medically necessary services, supplies, and medications

  The Plan limits benefits for home health care services.

- Hospice care services, as long as the care is provided through an accredited hospice care program and is approved by the Claims Administrator. Covered services include:
  - Coordinated home care;
  - Medical supplies and dressings;
  - Medications;
  - Nursing services (skilled and non-skilled);
  - Occupational therapy;
  - Pain management services;
  - Physical therapy
  - Physician visits

To be eligible for hospice care benefits, you must be terminally ill and your attending physician must certify that your life expectancy is six months or less. Your physician also must indicate that you will no longer benefit from standard medical care, or that you have elected to receive hospice care rather than standard care. In addition, a family member or friend must be available to provide custodial-type care between hospice care visits if you are receiving hospice care at home.

The Plan does not pay hospice care benefits for:

- Home-delivered meals or homemaker services
- Respite care
- Traditional medical services to treat the terminal illness, disease, or condition

- Transportation, including – but not limited to – ambulance transportation
- Care provided by a family member or friend

There may be instances when short episodes of traditional care are appropriate – even if you remain in the hospice setting. Even if the traditional services are not eligible for hospice care benefits, the Plan may still cover them.

- Human organ and tissue transplants. If you are a PPO participant and you receive such services from a network provider, you do not have to meet a deductible before the Plan pays benefits. Covered human organ and tissue transplant services include the following:
  - Heart
  - Lung
  - Heart/lung
  - Liver
  - Pancreas or pancreas/kidney
  - Cornea
  - Kidney
  - Bone marrow
  - Heart valve
  - Muscular-skeletal
  - Parathyroid

- The Plan pays benefits for both the recipient and donor of the covered transplant as long as the following requirements are met:
  - Both the donor and recipient each have coverage and their respective plans pay benefits.
  - If you are the recipient and the donor does not have coverage from any other source, the Plan pays benefits for both you and the donor. The Plan pays for the donor and charges the benefits against your own.
  - If you are the donor and coverage is not available to you from any other source, the Plan pays benefits for you. However, the Plan does not pay benefits for the recipient.

In addition, the Plan pays benefits for travel and lodging expenses, provided the hospital where the transplant is being performed is at least 100 miles from your residence. If this is the case, the Plan pays benefits for the round-trip transportation of both the patient and a companion or parent. The Plan also pays benefits for related lodging expenses of the patient and his or her companion or parent.

Please Note: the Plan does not pay human organ transplant benefits for the following:

- Cardiac rehabilitation services provided more than three days after the recipient is discharged from the hospital;
- Transportation by air ambulance for the donor or the recipient;
- Travel time (and related expenses) required by a provider;
- Drugs that are investigational in nature

- Medical and surgical dressings, supplies, casts, splints, trusses, braces, and crutches;

- Services related to mastectomies, including:
  - Reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - Prostheses and physical complications of all stages of the mastectomy (including lymphedemas)

- Vision exams and necessary hardware, only if the exam and hardware are part of your first pair of lenses following cataract surgery;

- Oxygen and its administration, including the rental of equipment for its administration;

- Private duty nursing services provided by an R.N. or L.P.N. in a hospital or other health care facility as approved by the Claims Administrator;

- Prosthetic appliances (including artificial limbs and eyes), prosthetic devices, and orthotics (including an initial wig following cancer treatment). The Plan also pays benefits for special appliances and surgical implants when required to replace all or part of:
  - An organ or tissue of the human body;
  - The function of a nonfunctioning or malfunctioning organ or tissue

The Plan pays benefits for adjustments, as well as the charges associated with repair and replacement of a covered prosthetic device, special appliance, or surgical implant (if a patient's condition changes or there's significant wear on the appliance). The Plan does not pay benefits for dental appliances (except for intra-oral devices used in connection with the temporomandibular joint dysfunction treatments), and the replacement of cataract lenses when a prescription change is not required. With regards to orthotics, the plan pays benefits based on medical necessity only. The Plan does not pay benefits for orthotics when used for comfort only.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Prescription Drug Coverage Expenses Covered

The prescription drug coverage expenses covered include, but may not be limited to the following: *Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses covered under the Plan.*

- Federal legend drugs (except those listed as not covered);
- Insulin;
- Disposable insulin needles/syringes;
- AZT (Retrovir);
- Chemotherapeutics;
- Fluoride Vitamins to age 19;
- Immunosuppressants;
- Injectables, other than Insulin;
- Pre-natal Vitamins;
- Retin-A, up to age 25;
- Diabetic diagnostics;
- Compound medication of which at least one ingredient is a legend drug;
- Any other drugs that under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber

For medications covered under an HMO option, please refer to the HMO SPD or Certificate of Coverage for further information.

Mental Health and Substance Abuse Treatments Expenses Covered

The covered mental health and substance abuse expenses include, but may not be limited to the following: *The Plan limits benefits for inpatient mental health and substance abuse treatments. Please contact the Claims Administrator for details regarding the limits that apply.*

- Inpatient facility and physician services provided for mental health and substance abuse, including:
  - Detox and rehab substance abuse services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance abuse treatment facility;
  - Services provided in an intermediate mental health/substance abuse treatment care facility;
  - In-home mental health care;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program

The Plan considers an inpatient hospital stay to be one for which a room and board charge is made. Care provided in an intermediate care facility only includes continuous treatment of not less than three hours and not more than twelve hours in a 24-hour period. Intermediate care facility services do not include a hospital inpatient stay.

- Outpatient facility and physician services provided for mental health and substance abuse, including:
  - Detox and rehab substance abuse services;
  - Services provided in a hospital (including emergency room visits);
  - Services provided in a substance abuse treatment facility;
  - Services provided in an intermediate mental health/substance abuse treatment care facility;
  - Lab tests related to treatment;
  - Medication check visits;
  - Services received through a partial hospitalization (day/night) treatment program

A $15 copay per office visit generally applies to all in-network outpatient visits related to mental health or substance abuse treatments. In addition, the first six outpatient visits per diagnosis (whether individual and/or group) are covered under the EAP.

- Emergency care
  - You must present a real or potential danger to yourself or to others;
  - Your judgment, impulse control, or functioning must be significantly impaired;
  - You must have immediate and severe medical complications concurrent with or as a result of psychiatric or substance abuse illness and its treatment;
  - Services provided in an intermediate mental health/substance abuse treatment care facility;

- Lab tests related to treatment

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Medical Expenses Not Covered

The medical expenses **not** covered include, but may not be limited to the following: *Please contact the Claims Administrator with questions regarding those medical expenses not covered.*

- Any condition, disease, defect, ailment, or injury that arises out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive benefits in whole or in part. It also applies whether or not you claim the benefits or compensation, and regardless of whether you recover benefits from any third party.
- Expenses for which benefits are payable under Medicare Part A and/or Medicare Part B or would have been payable if you had applied for Part A and/or Part B (except as specified elsewhere under the plan or as otherwise prohibited by federal law).
- Charges related to cosmetic surgery or related Hospital admissions, unless made necessary:
  - by an Injury;
  - for correction of congenital deformity when necessary to perform a normal body function;
  - for reconstructive surgery as necessary for the prompt treatment of a diseased condition
- Any service or supply that is related to weight loss or the treatment of obesity (except for the surgical treatment of morbid obesity).
- Services associated with the treatment of infertility, including; Artificial insemination; Fertilization (such as in-vitro or GIFT); Procedures and tests related to fertilization; Infertility drugs and related services that follow the diagnosis of infertility.
- Care received in an emergency room that is not considered emergency care (except as specified under the plan).
- Services or supplies that you receive at a health spa or similar type of facility.
- Self-help training and other forms of non-medical self care (except as provided under the plan).
- Physical exams and immunizations required.
- Radial keratotomy or keratomileusis, or excimer laser photo refractive keratectomy.
- Speech therapy, unless the therapy is expected to restore speech to a person who has lost speech function as a result of a disease or injury.

For the excludable medical expenses not covered under the HMO, please refer to the HMO SPD for further information.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Prescription Drug Coverage Expenses Not Covered

The Prescription Drug Coverage expenses **not** covered include, but may not be limited to the following: *Please contact the Claims Administrator with any questions regarding the prescription drug coverage expenses not covered.*

- Drugs or medicines that are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription
- Drugs prescribed for cosmetic reasons
- Vitamins (unless prescribed)
- Oral contraceptives, unless medically necessary
- Drugs used for the treatment of infertility or relating to conception
- Drugs used in the treatment of erectile dysfunction or impotence, regardless of the origin, whether biological or psychological
- Hair treatments
- Anti-wrinkle treatment
- Blood glucose testing machines
- Bilogicals
- Nutritional dietary supplements
- Over-the-counter medications
- Smoking cessation materials

For medications not covered under the HMO plan, please refer to the HMO SPD for further information.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Coordination of Benefits (COB)

If you or your dependents have coverage under another medical plan or program, your benefits under the Plan coordinate with benefits outside the Plan to help eliminate duplicate payments for the same services. See the "*Coordination of Benefits (COB")* in the **Overview** section of this Handbook to learn more about the plan's COB features.

Please Note: If you or your covered dependent becomes entitled to Medicare due to end-stage renal disease, the Plan continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payer of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

Filing a Claim

Generally, In-Network providers file claims on your behalf. If so, the Claims Administrator will send payments directly to the provider. You will be sent a statement itemizing what has been paid.

If your provider does not file claims on your behalf, you must file your claims as follows:

- Complete the appropriate claim form. Claim forms can be obtained from the Claims Administrator by phone via MySource for Human Resources at 1-888-640-3320, or online via the MySource for Human Resources Web site www.mysourceforhr.com.
- Attach copies of all available medical bills that should be considered for plan benefits. These bills should include:
    - Name of patient
    - Name and Social Security number of employee
    - Date of treatment
    - Type of treatment
    - Charge for the treatment
    - Provider of the treatment
    - Any other information that clearly indicates the medical expense
- Mail your completed claim form to the address on the back of your benefit plan ID card.
- Submit your claim to the Claims Administrator as soon as possible after you receive the covered service. If you do not file a claim within the required time period, the plan does not consider it for payment.

The Claims Administrator will process your claim. Generally, claim payments are sent directly to providers. However, there may be situations where payments are sent directly to you (i.e. your provider is not a member of the network). Any claims submitted after 1 year from the date of service may not be considered for payment. If you have any questions regarding filing claims, contact MySource for Human Resources at 1-888-640-3320.

Claim Denial and Appeal Process

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator decides your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim improperly, you receive a notice of the improper filing and how to correct it within five days after your pre-service claim is received. Once you receive notice, you then have 45 days to provide any needed information. If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Outline the claims appeals process.

Post-Service Claims

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you are notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information. If you receive a denial notice, the notice will:

- Explain the reasons for the denial
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary
- Refer you to the part of the Plan upon which the denial is based
- Outline the claims appeals process.

Urgent-Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain.

You receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator takes into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent-care claim improperly, you receive a notice of the improper filing and how to correct it within 24 hours after the Claims Administrator receives your urgent–care claim. Once you receive this notice, you then have 48 hours to provide the requested information.

If You Have Questions
If you have a question or concern regarding a benefit determination, contact the claims administrator or the MySource Participant Advocacy service through the MySource for Human Resources toll-free number (1-888-640-3320) before you request a formal appeal. If you are not satisfied with a benefit determination, you can appeal it.

You receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Plan receives the requested information; or
- The end of the period that you have to provide the specified additional information.

If you receive a denial notice, the notice will:

- Explain the reasons for the denial
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary
- Refer you to the part of the Plan upon which the denial is based
- Outline the claims appeals process

Concurrent-Care Claims

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request meets that of an urgent care claim (as defined above), the Claims Administrator decides your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment does not involve urgent care, the Claims Administrator treats your claim as either a pre-service or post-service claim (as applicable and considers the claim according to the post-service or pre-service time frames; whichever applies.

Appeal to Claims Administrator

If your initial claim is denied in whole or in part (as described above), you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the claim denial notification.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Denies Your Claim on Appeal

If the Claims Administrator denies your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and

- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Second Appeal to the Plan Administrator for Pre and Post Service Claims

If the Claims Administrator denies all or any portion of your pre or post service claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator by sending a written request for review to the Plan Administrator within 180 days of your receipt of the Claims Administrator's notice of claim denial.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal.

If the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Plan Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Plan Administrator Denies Your Claim on Appeal

If the Plan Administrator denies your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and

- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If the Plan Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Plan Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Continuation Coverage

General

Generally, the Medical Coverage is only available to you if you are actively at work. However, there are certain leaves during which you can continue your coverage. They are:

Short Term Disability Leave – Medical coverage for you and your eligible dependents continue while you are receiving STD benefits or if an appeal is pending in accordance with the Plan provisions. Your contributions for the dental coverage will continue to be deducted from your check.

Long Term Disability Leave – Medical coverage for you and your eligible dependents continue while you are receiving LTD benefits or if an appeal is pending in accordance with the Plan provisions. You must continue to make your required contribution.

Family Medical Leave (FMLA) – Medical coverage for you and your eligible dependents continues at the same level of contribution and under the same conditions if you are granted a leave of absence under the Family Medical Leave Act (FMLA). In the event you are on FMLA leave, you must continue to make your required contribution.

The Company may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) – If you are absent from employment because of service in the "uniformed services" (as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")), you may elect to continue coverage under the Plan during the period of your service to the extent provided in USERRA and the NiSource Military Leave of Absence Policy.

COBRA Coverage

In the event your benefits terminate under the Plan, you may be eligible to continue your medical coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") provided you experience a COBRA qualifying event. Please see the "*Continuation of Benefits (COBRA)*" section of the Overview for further details.

Additional Information

Your Rights Under the Newborn's and Mother's Health Protection Act

Under Federal law, the Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that the provider obtain authorization from the Plan for prescribing a length of stay that is not in excess of the above periods.

Women's Health and Cancer Rights Act of 1998

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedmas (swelling associated with the removal of lymph nodes)

Contact Information

Specific coverage related questions should be directed to MySource for Human Resources by going to their Web site or using their automated telephone system.

Coverage Option	Contact
• **Medical Plan Coverage Options** — PPO, Standard Plan 1 (Traditional Indemnity), Standard Plan 2 (Catastrophic Indemnity)	Anthem Insurance Companies, Inc. 1-888-640-3320 (MySource for Human Resources) www.mysourceforhr.com (links to www.anthem.com – group ID NSU) The *Claims Administrator* can be contacted by phone via the MySource for Human Resources automated telephone system
• **Mental Health and Substance Abuse Services**	Value Options 1-888-640-3320 (MySource for Human Resources)
• **Prescription Drug Service**	Walgreens Healthcare Plus 1-888-640-3320 (MySource for Human Resources) www.mysourceforhr.com 1-800-265-1807 (mail order pharmacy customer service) 1-800-749-0009 (mail order refill) The *Claims Administrator* can be contacted by phone via the MySource for Human Resources automated telephone system

General Plan Information

The Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974).

Plan Type:	Medical Plan
Plan Number:	501
Claims Administrator for the Medical Plan:	Anthem Insurance Companies Inc. P.O. Box 37010 Louisville, KY 40233 www.anthem.com
Claims Administrator for the Prescription Drug Coverage:	Walgreens Health Initiatives P.O. Box 545 Deerfield, IL 60015 www.walgreenshealth.com
Type of Insurance:	Self–Funded.
Contribution Source:	Employee and Employer

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NiSource Inc.

Benefits Program Overview

Summary Plan Descriptions

DRAFT DOCUMENT FOR DISCUSSION PURPOSES ONLY

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Contents (continued)

The Benefit of Choice - An Introduction to the Program

As an employee of NiSource Inc. ("Company") or one of its affiliates (to the extent described below), you have the benefit of choosing your own portfolio of benefit coverages from the NiSource Benefits Program ("Program") each year.

The following employers participate in the Program as described in the benefit plans. Each one of these companies is referred to as a Participating Employer:

- NiSource Inc.
- NiSource Corporate Services Company
- NiSource Development Company, Inc.
- NiSource Energy Technologies, Inc.
- Northern Indiana Public Service Company
- Kokomo Gas and Fuel Company
- Northern Indiana Fuel and Light Company, Inc.
- Bay State Gas Company
- Northern Utilities, Inc.
- Granite State Gas Transmission, Inc.
- Columbia Energy Group
- Columbia Gas of Kentucky, Inc.
- Columbia Gas of Maryland, Inc.
- Columbia Gas of Ohio, Inc.
- Columbia Gas of Pennsylvania, Inc.
- Columbia Gas of Virginia, Inc.
- Columbia Gas Transmission Corporation
- Columbia Gulf Transmission Company
- NiSource Retail Services, Inc.

- Northern Indiana Trading Company, Inc.
- NI Energy Services, Inc.
- EnergyUSA-TPC Corp.
- CNS Microwave, Inc.

*

This handbook serves as the Summary Plan Descriptions ("SPDs") of all NiSource benefit plans as of January 1, 2005. The information enclosed has been prepared to summarize the benefits in an easy to understand format and is not intended to replace or supercede the official plan documents. The official plan documents are the governing documents in the event that questions arise or if there is a conflict between an SPD and an official plan document. While the Company and the Participating Employers intend to continue the plans, policies and/or options described in this handbook, the Company (and the Participating Employers as applicable) reserve the right to change, modify or discontinue these plans, policies and/or options at their discretion.

Benefit Plans at-a-Glance

The Company offers you the following coverages in accordance with the terms of the applicable benefit plan (identified below). (*Details of each benefit plan can be found in the individual sections of this handbook.)*

- Medical and Prescription Drug Coverage
  (NiSource Consolidated Flex Medical Plan – referred to as the "Medical Plan")
- Dental Coverage
  (NiSource Dental Plan – referred to as the "Dental Plan")
- Flexible Spending Accounts
  (NiSource Flexible Benefits Plan – referred to as the "FSA Plan")
  - Health Care (referred to as the "Health Care Flexible Spending Account" or "Health Care FSA")
  - Dependant Care (referred to as the "Dependent Care Flexible Spending Account" or "Dependent Care FSA")
- Vision Coverage
  (NiSource Vision Plan – referred to as the "Vision Plan")
- Travel Accident Coverage
  (NiSource Travel Accident Plan – referred to as the "Travel Accident Plan")
- Short-Term Disability Coverage
  (NiSource Short-Term Disability Plan – referred to as the "Short-Term Disability Plan")
- Long-Term Disability Coverage
  (NiSource Long-Term Disability Plan – referred to as the "Long-Term Disability Plan")
- Life and AD&D Coverages
  (NiSource Life Insurance Plan – referred to as the "Life and AD&D Plan")

Contact Information for Benefit Plans

For answers to specific benefit-related questions, contact the applicable benefit plan's Claims Administrator (indicated below and listed in the "*General Program Information*" subsection of this **Overview**) via the applicable Web site or customer service representative telephone number listed below.

BENEFIT PLAN	CLAIMS ADMINSTRATOR CONTACT INFORMATION
HEALTH:	Anthem Insurance Companies, Inc. 1-888-640-3320 (MySource for Human Resources) www.mysourceforhr.com (links to www.anthem.com – group ID NSU)
MENTAL HEALTH and SUBSTANCE ABUSE SERVICES:	Value Options 1-888-640-3320 (MySource for Human Resources)
PRESCRIPTION DRUG SERVICES:	Walgreen's Healthcare Plus 1-888-640-3320 (MySource for Human Resources) www.mysourceforhr.com 1-800-265-1807 (mail order pharmacy customer service) 1-800-749-0009 (mail order refill) The Claims Administrator can be contacted by phone via the MySource for Human Resources automated telephone system.
DENTAL	CIGNA www.mysourceforhr.com (link to www.cigna.com) 1-888-640-3320 (MySource for Human Resources) The Claims Administrator can be contacted by phone via the MySource for Human Resources automated telephone system
VISION	VSP www.mysourceforhr.com (link to www.vsp.com) 1-888-640-3320 (MySource for Human Resources) The Claims Administrator can be contacted by phone via the MySource for Human Resources automated telephone system.
LIFE and AD&D	The Prudential Insurance Company of America www.mysourceforhr.com (link to www.prudential.com) 1-888-640-3320 (MySource for Human Resources) The Claims Administrator can be contacted by phone via the MySource for Human Resources automated telephone system.

TRAVEL ACCIDENT	NiSource Corporate Services Company Attention: Benefits Administration Department www.mysourceforhr.com (link to 1-888-640-3320 (MySource for Human Resources) The Claims Administrator can be contacted by phone via the MySource for Human Resources automated telephone system.
DISABILITY Short-Term Disability Insurance Coverage: Long-Term Disability Insurance Coverage:	ESIS www.mysourceforhr.com (link to ***ESIS.com***) 1-888-640-3320 (MySource for Human Resources) The Claims Administrator can be contacted by phone via MySource for Human Resources automated telephone system. The Prudential Insurance Company of America www.mysourceforhr.com (link to www.prudential.com) 1-888-640-3320 (MySource for Human Resources) The Claims Administrator can be contacted by phone via the MySource for Human Resources automated telephone system.
FLEXIBLE SPENDING ACCOUNTS	FlexBen Corporation www.mysourceforhr.com (link to www.flexben.com) 1-888-640-3320 (MySource for Human Resources) The Claims Administrator can be contacted by phone via the MySource for Human Resources automated telephone system.

Accessing Benefits Information

You can access your benefits information through MySource for Human Resources, a Web site and telephone system designed to centralize your Human Resources information and provide tools to help you manage the following benefit plans:

- Health and welfare benefits.
- Retirement and investments – 401(k) and pension.
- Other voluntary programs, including family counseling and referral services.

To access MySource for Human Resources, go to the NiSource Intranet (called MySource), log on to the secure Web site at www.mysourceforhr.com. MySource can be accessed 24 hours a day, seven days a week. Customer service associates are also available to answer questions at the MySource automated telephone system at 1-888-640-3320.

Eligibility

You and your eligible dependents *(as defined in the applicable individual section of this handbook)* will be eligible to elect to participate in the benefit plans when and to the extent provided under the applicable benefit plan.

Certain benefit plans are maintained pursuant to one or more collective bargaining agreements. Copies of such agreements can be obtained upon written request to the Company and copies also are available for examination at the Company's principal offices during regular business hours.

Enrollment

When you first become eligible to participate in a benefit plan, and each year during annual enrollment, you have the opportunity to select coverages for you and your eligible dependents. .

- Generally, you must enroll for the medical, dental, flexible spending, vision, supplemental and dependent life and AD&D and supplemental long-term disability coverages within 31 days following the date on which you become eligible for such coverage. *(The individual sections of this handbook contain additional information about enrollment to each plan.)*

- You are automatically enrolled for short-term disability, basic long-term disability and travel accident and basic life and AD&D coverages upon the date you become eligible for such coverage.

To enroll, you must log on to the MySource Web site at www.mysourceforhr.com or call MySource for Human Resources at 1-888-640-3320.

The enrollment materials detail how to enroll online and by phone. If you do not enroll within the 31-day period described above, as applicable *(the deadline date is included in the enrollment materials),* you will automatically receive default coverage *(as described in the applicable individual section of this handbook)*, if applicable, for the remainder of that calendar year. **Please Note:** Dependents will not be eligible to receive any of the coverages if you fail to enroll them during your initial 31-day period.

Special Enrollment Rights and Opportunities

Please see the *"Changing and Continuing Your Coverages"* subsection of this **Overview** for details.

Dual Coverages

If you and your spouse both work for the Company or a Participating Employer, you can:

- Decide to have one of you enroll as the employee and cover the spouse and all other eligible dependents in a plan or plans under the same coverage options, or

- Decide to enroll separately and select coverage options independent of one another. If you choose this option, you cannot cover each other under a plan and only one of you can cover your dependent children, if applicable, enrollment Pursuant to a Qualified Medical Child Support Order (QMCSO)

The Program also provides medical, prescription drug, vision, and dental coverage for your child (as well as participation in the health care flexible spending account) pursuant to the terms of a

Qualified Medical Child Support Order (QMCSO). This may apply even if you do not have legal custody of the child; the child is not dependent on you for support, and regardless of any enrollment restrictions that might otherwise exist for dependent coverage. If the Company or Participating Employer receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or state agency may enroll the dependent child. Additionally, the employer may withhold from your wages any contributions required for such coverage.

You may obtain, without charge, a copy of the benefit plans' QMCSO procedures from the Company.

Special Rule for Rehired Employees

If you terminate employment and are rehired after your termination date, the benefit elections that were in effect on the date of your termination **will not be** automatically reinstated. You will need to re-elect coverages once you again become eligible upon your return.

Annual Enrollment

Each year, at annual enrollment, you will receive information regarding the benefit plans. If you do not enroll within the annual enrollment period, your current coverages remain in effect for the upcoming plan year (at the applicable rates). You will be advised of any new benefit plans, plans that require enrollment and the deadline dates. **If you want to participate in the health and/or dependent care flexible spending accounts, you need to enroll each year. Your flexible spending account contribution elections will not carry from one plan year to the next.**

Opt-Out Credit

If you have coverage elsewhere and decline medical or dental coverage under the Medical or Dental Plans, you may be eligible for an opt-out credit, if available. Please refer to the enrollment material to see if this option is currently being offered.

ID Cards

Once you enroll and become a participant, you will receive identification cards for the following benefit plans at your home address.

- Medical; and
- Prescription Drug

There are no ID cards for the Vision Plan, Dental Plan or other coverages.

When Coverages Begin and End

Please see the individual sections of this handbook for a complete description of when the coverage begins and ends with respect to each benefit plan.

Changing and Continuing Coverages

In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire plan year. However, the Internal Revenue Service will allow you to enroll for or change *certain* coverages during the year under certain circumstances. For example, you may change your coverage if they experience a "qualified life event" that affects you, or your spouse's, or your dependent's eligibility for benefits under the Medical Plan, the Dental Plan, the Vision Plan, the FSA Plan, the Life and AD&D Plan and the Long-Term Disability Plan. You must contact a customer service associate at MySource for Human Resources at 1-888-640-3320 to request a change in coverage within 31 days of the date of the qualified life event.

A qualified life event is any of the following circumstances that may affect coverage:

- You get a divorce, become legally separated, or your marriage is legally annulled.
- Your spouse or dependent dies.
- Your dependent becomes ineligible for coverage (e.g., he or she reaches the eligibility age limit, ceases to be a student, or gets married).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your spouse, or your dependent experiences a change in employment status (e.g., gain or terminate employment, change worksites) that leads to a loss or gain of eligibility for coverage.
- You, your spouse or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa, strike or lockout, begin or return from an unpaid leave of absence).
- You, your spouse, or your dependent has a change in home address (outside the network service area).
- You, your spouse, or your dependent experiences a significant change in cost or coverage (this does not apply to the health care flexible spending account).
- You qualify for special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") if you involuntarily lose coverage. For example, you may qualify for special enrollment if (i) you acquire an eligible dependent after your employment begins, or (ii) you (or your dependent) were covered under another group health plan or had other health insurance coverage when you declined coverage and you (or your dependent) is no longer eligible for and covered under that other coverage.

- The benefit plan receives a Qualified Medical Child Support Order (QMCSO) or other court order, judgment, or decree that requires you to enroll a dependent.
- You, your spouse, or your dependent qualifies for or loses Medicare or Medicaid coverage.
- Any other event determined to be a qualified life event under the Internal Revenue Code.

Coordination of Benefits (COB)

If you or your dependent have coverage under another medical, prescription drug, vision or dental plan or program, your medical, prescription drug, vision and dental benefits under the benefit plans coordinate with those other benefits to help eliminate duplicate payments for the same services.

The following provisions of this *"Coordination of Benefits (COB)"* subsection apply to the Medical Plan and the Dental Plan. Please see the Vision Plan SPD for details about coordination of benefits provisions applicable to the Vision Plan.

Coordinating Plans

Types of plans that normally coordinate benefits include, but may not be limited to, the following:

- Group or blanket plans or coverages provided by an employer, union, trust, or other similar sponsor.
- Other group or prepayment health care plans or coverages that covers you or your dependents, including student coverage provided through a school above the high school level.
- Federal government benefit programs, including Medicare or Medicaid. (Medicaid or any other plan, program, policy or arrangement will not be included if, by its terms, it does not allow coordination.)
- Automobile insurance plans in the case of accidents, when inclusion is not prohibited by law.
- Other plans required or provided by law.

These coordination provisions do not apply to individual or private insurance plans. Any benefits to which you may be entitled are considered for possible coordination.

How Coordination Works With Other Group Plans

If you are covered by more than one of the types of plans mentioned above, one plan is **primary**. The primary plan pays benefits first without considering the other plans. Then - based on what the primary plan pays - the other plans may pay a benefit (if any).

If your coverage under the applicable benefit plan is primary, the benefit plan pays the amount payable under such plan.

If your coverage under the applicable benefit plan is secondary, the primary plan pays its benefits first. Then, the benefit plan pays the lesser of:

- The amounts payable under the applicable benefit plan; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay will not exceed 100 percent of the eligible expense.

Determining the Order of Payment

When benefits coordinate, the plans or coverages involved determine which pays benefits first ("primary plan"), and then second ("secondary plan"). Below are the benefit plans' guidelines for determining which is primary:

- If the plan has no coordination of benefits provision, it automatically is primary.
- If medical benefits are available under an automobile insurance plan, the medical plan will always be considered secondary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA beneficiary, or retired employee is primary and pays benefits first. The other coverage is secondary and only pays any remaining eligible expenses.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. If the other plan does not follow the Birthday Rule and as a result both coverages would be considered either primary or secondary, the order of benefits will be determined at the option of the applicable Claims Administrator**. [Mike, is the parent without a "Birthday Rule" become primary?]**

The "Birthday Rule"
Under the "Birthday Rule" the plan of the parent whose birthday falls earlier in the calendar year is the primary plan and the other parent's plan is secondary.

- In the case of a divorce or separation, the following order will establish responsibility for payment:
  - If there is a court order that requires a parent to take financial responsibility for the relevant coverage for the child, that parent's plan is always primary. If the parent with financial responsibility does not have coverage, but the parent's spouse does, such spouse's plan is primary.
  - The plan of the parent with custody of the dependent child usually pays benefits before the plan of the other parent or the plan of a stepparent.

- If the parent with custody of the child remarries and the stepparent's plan also covers the child, the custodial parent's plan pays first and the stepparent's (custodial parent's spouse's) plan pays second. The plan of the parent without custody pays third, and the noncustodial parent's spouse's plan (if any) pays last.

- The plan of the parent without custody of the child pays before the non-custodial stepparent.

If a determination cannot be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

How Coordination Works With Medicare

Under current law, you and your dependents become eligible for Medicare at age 65. (If you become disabled, you may become Medicare-eligible before age 65.)

You should notify a MySource customer service associate if you start Medicare benefits. The way medical coverage under the benefit plans coordinates with Medicare depends on your age and whether you are an active or inactive employee.

How does Coordination of Benefits Work for Active Employees

If you are an active employee or covered by another active employer plan, and you or your spouse become Medicare-eligible, you or your spouse may have either of the following:

- Medical coverage under both the Medical Plan and Medicare (the Medical Plan under the Program is primary, it pays benefits as described in this handbook, and Medicare is secondary); or

- Coverage under Medicare only (if that is what you have elected).

If you are an active employee and you and your spouse are covered under the Medical Plan, Medicare coverage becomes secondary. You may decline coverage under the Medical Plan in which case Medicare would be the primary carrier. Your spouse may, if age 65 or older, make a separate Medicare election. However, your spouse may not elect medical coverage under the Medical Plan if you do not elect coverage.

Please Note:
If you or your covered dependent becomes entitled to Medicare due to end-stage renal disease, the Program continues to pay as primary during the first 30 months of dialysis or the first 30 months of treatment in connection with a kidney transplant. Thereafter, Medicare generally becomes the primary payor of benefits. Contact your local Social Security Administration office to get more information about enrolling in Medicare.

How does Coordination of Benefits Work for Inactive Employees

If you are covered under the Medical Plan but are no longer an active employee (including retirement or disability), and you or your spouse is Medicare-eligible, then Medicare is the primary payer regardless of your or your covered spouse's age. You are responsible for notifying a MySource customer service associate if you or your spouse becomes Medicare-eligible.

Claim Denial and Appeal Process

General

The Company delegates the authority to decide claims and certain appeals to the applicable Claims Administrator (listed in the *"General Program Information"* subsection of this **Overview**). The Claims Administrator adheres to specific timeframes for notifying you of its determination regarding your claim. If your claim for benefits is denied (in whole or in part), formal procedures are in place if you want to appeal the denial.

There are different categories of claims, and each is subject to different timeframes for notifying you of the Claims Administrator's determination if your claim has been denied (in whole or in part).

You may have someone else represent you in any of the review processes as long as you inform the Claims Administrator or Plan Administrator, as appropriate (in writing) of the name of the person who will represent you.

For details regarding how to file a claim and the claim denial and appeal processes for each of the benefit plans, please see the individual sections of the handbook.

Legal Action

You cannot bring any legal action against a benefit plan, unless you first complete all the steps of the applicable appeals process described in this handbook. Once you complete that process, you can bring legal action against the applicable benefit plan. If you decide to take legal action, you must do so within three years of the day the charge is incurred.

Continuation of Benefits (COBRA)

This subsection contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical Plan, Dental Plan, Vision Plan and Health Care Flexible Spending Account option of the FSA Plan (referred to collectively as the "Plan" for purposes of this subsection.) Special COBRA provisions apply under the FSA Plan and are explained in a separate paragraph below. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this subsection or contact the applicable Claims Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this subsection. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the cost of such coverage. The cost of coverage is up to 102 percent of the total premium rate (a two percent administrative cost is added to the actual cost of the coverage). If you are entitled to extended coverage (as described below), you will be required to pay up to 150 percent of the full cost of the coverage. These costs are subject to change.

You will have 45 days from the date of your coverage election to submit your first premium payment. This premium payment will include all premiums prior to your election for the period of COBRA continuation coverage. After your initial premium payment is remitted, you or your dependents will be billed monthly for the elected coverage. If payment is not received within 30 days of the monthly due date, COBRA coverage will be cancelled.

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if you lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

With respect to retiree Medical Plan coverage, sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to a Participating Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Medical Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if the bankruptcy results in the loss of their coverage under the Medical Plan.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to a Participating Employer (with respect to Medical Plan coverage only), or you become entitled to Medicare benefits (under Part A, Part B, or both), the Participating Employer must notify the Plan Administrator of the qualifying event.

Notice of Some Qualifying Events

For the other qualifying events (<u>divorce</u> or <u>legal separation</u> of the employee and spouse or a <u>dependent child's losing eligibility for coverage</u> as a dependent child), employees must notify the Plan Administrator within 60 days after the qualifying event occurs. This notice must be provided to: MySource for Human Resources.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator (in a form prescribed by the Plan Administrator) within 60 days of the disability determination by Social Security and before the end of the initial 18-month period, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must also notify the Plan Administrator within 30 days of the date the Social Security Administration determines that you or your dependent are no longer disabled.

Second qualifying event extension of 18-month period of COBRA continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent

child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. For example, when the qualifying event is a termination of employment, COBRA continuation coverage for you, your spouse and dependent children can last up to 18 months. If within that initial 18-month period you become legally separated or divorced (i.e., experience a second qualifying event), COBRA continuation coverage will be extended by an additional 18 months (for a total of 36 months from the date of the termination of employment) for your spouse and dependent children who lose coverage due to the divorce or legal separation.

COBRA Continuation Coverage Under the Health Care Flexible Spending Account Option of the FSA Plan

Notwithstanding the preceding paragraphs of this subsection, special COBRA provisions apply to the Health Care Flexible Spending Account Option of the FSA Plan. Upon experiencing a qualifying event, which causes a loss of coverage under the Health Care Flexible Spending Account option of the FSA Plan, you may continue your current contributions to your Health Care Flexible Spending Account on an ***after-tax*** basis through COBRA for the remainder of the Plan year in which your active coverage ended. This means that you will lose the pre-tax benefit of the FSA Plan by continuing coverage through COBRA. However, COBRA continuation coverage under the Health Care Flexible Spending Account option of the FSA Plan allows you to continue to submit eligible claims for the remainder of the Plan year. If COBRA continuation coverage is not elected, only those expenses incurred prior to the qualifying event will be eligible for reimbursement. Please see the "*Continuation of Coverage and COBRA Coverage*" subsection of the FSA Plan SPD for additional information.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations set forth above (i.e., 18, 29 or 36 months), COBRA continuation coverage will end on the earliest to occur of the following:

- The date you first become entitled to benefits under Medicare.
- The date on which all Participating Employers cease to provide any group health plan or coverage to any employee.
- If you fail to make a required contribution, the end of the period for which the last contribution was made.
- The date you first become covered under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than a pre-existing condition that does not apply to (or is satisfied by) you pursuant to applicable law. (Please see the "*Coordination with HIPAA*" provisions set forth below for additional information.)

Coordination with HIPAA

Under COBRA, your rights to continue coverage terminate if the employee becomes covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If they become covered by another group health plan and that plan contains a pre-existing condition limitation that affects them, your COBRA continuation coverage cannot be terminated. The Health Insurance Portability and Accountability Act ("HIPAA") limits the extent to which employers' group health plans can impose pre-existing condition exclusions. Thus, if another plan's pre-existing condition exclusion cannot apply to the employee because of HIPAA, your entitlement to COBRA continuation coverage under the group health plan may terminate.

Questions

Questions concerning the Plan or the employee's COBRA continuation coverage rights should be addressed to the contact identified below. For more information about rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District Offices are available through EBSA's Web site.

To enroll in COBRA, contact MySource at 1-888-640-3320.

Notification of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. If your home address changes while on COBRA, MySource should be notified.

You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

NiSource Corporate Services Company
Benefits Administration Department
801 East 86th Avenue
Merrillville, Indiana 46410
(219) 853-5200

Certification of Group Health Coverage

If you or a covered dependent are no longer eligible for coverage under the Medical Plan, you will automatically receive a certification of group health plan coverage. A certification of group health plan coverage can be obtained from a MySource customer service associate anytime during the 24-month period after your coverage under the Medical Plan ends.

Additional Information

Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an illness, a sickness, or a bodily injury incurred by your or one of your covered dependents (a "covered person").

An "Other Party" includes, but is not limited to, any of the following:

- the party or parties who caused the illness, sickness or bodily injury;
- the insurer or other indemnifier of the party or parties who caused the illness, sickness or bodily injury;
- a guarantor of the party or parties who caused the illness, sickness or bodily injury;
- the covered person's own insurer (for example, in the case of uninsured or underinsured coverage, no-fault coverage or med-pay);
- a worker's compensation insurer (including the covered person's employer if worker's compensation is self-insured);
- any other person, entity, policy or plan that is liable or legally responsible in relation to the illness, sickness or bodily injury.

Benefits may also be payable under the applicable benefit plan in relation to the illness, sickness or bodily injury. When this happens, the applicable benefit plan may, at its option:

- subrogate, that is, take over the covered person's right to receive payments from the Other Party. If so, the covered person or his or her legal representative must transfer to the applicable benefit plan any rights he or she may have to take legal action arising from the illness, sickness or bodily injury so that the applicable benefit plan may recover any sums paid under such benefit plan on behalf of the covered person;
- recover from the covered person or his or her legal representative any benefits paid under the applicable benefit plan from any payment the covered person receives or is entitled to receive from the Other Party.

As a condition of participation in the applicable benefit plan, the covered person agrees, and will cause his or her legal representative to agree to, cooperate fully with the applicable benefit plan in asserting its subrogation and recovery rights. The covered person or his or her legal representative must, upon request from the applicable benefit plan, provide all information and sign and return all documents necessary for the benefit plan to exercise its rights under this provision. Failure or refusal to execute such agreements or furnish information does not preclude the benefit plan from exercising its right to subrogation or obtaining full

reimbursement, and in such case, the benefit plan may cease paying benefits and reduce future benefits payable until full reimbursement is received.

The covered person shall provide notice to the NiSource Benefits Administration Department or its delegate within a reasonable time prior to the date that he or she expects to receive a payment from an Other Party. The covered person acknowledges that the applicable benefit plan has a right to intervene in any lawsuit involving an Other Party, and the covered person consents to the unfettered exercise of that right. The covered person further agrees that any funds received by him or her (or his or her legal representative) from any source for any purpose up to the amount of benefits paid under the applicable benefit plan shall be held in trust with either the person receiving benefits (or his or her legal representative) as trustee and the applicable benefit plan as beneficiary, until such time as the obligation under this provision is fully satisfied. Accordingly, such covered person or legal representative shall be deemed a fiduciary of the applicable benefit plan to the extent of the benefit plan assets that are so held in trust.

The applicable benefit plan will have a first lien and priority right upon any recovery, whether by settlement, judgment, mediation or arbitration, that the covered person (or his or her legal representative) receives or is entitled to receive from any of the sources listed above. This lien and priority right will not exceed the lesser of:

- the amount of benefits paid by the applicable benefit plan for the illness, sickness or bodily injury, plus the amount of all future benefits that may become payable under the applicable benefit plan that result from the illness, sickness or bodily injury. The applicable benefit plan will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

If the covered person or his or her legal representative:

- makes any recovery from any of the sources described above; and
- fails to reimburse the applicable benefit plan for any benefits that arise from the illness, sickness or bodily injury;

then:

- the covered person or his or her legal representative will be personally liable to the applicable benefit plan for the amount of the benefits paid under that benefit plan; and
- the applicable benefit plan may reduce future benefits payable for any illness, sickness or bodily injury by the payment that the covered person or his or her legal representative has received from the Other Party.

The applicable benefit plan's first lien and priority rights will not be reduced due to the covered person's own negligence; or due to the covered person not being made whole; or due to attorney's fees and costs. All attorney's fees and court costs, including the applicable benefit plan's attorney fees and court costs, are the responsibility of the covered person, not the benefit

plan. Neither the "common fund" or "make whole" doctrines shall be applicable with regard to the benefit plan, and as a condition of participating in the benefit plan, the covered person agrees that he or she will not retain counsel, unless such counsel agrees to not assert either of these doctrines during the representation.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- the employee;
- the employee's minor covered dependent;
- the estate of any covered person; or
- on behalf of any incapacitated person.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this Subrogation and Right of Recovery provision, regardless of state law and whether the minor's representative has access or control of any recovery funds.

If it becomes necessary for the applicable benefit plan to enforce this provision by initiating any action against any person, including the covered person's legal representative, then the covered person agrees to pay the benefit plan's attorney's fees and costs associated with the action, regardless of the action's outcome.

Overpayment of a Claim

If the plan pays benefits for the employee or a covered dependent, the employee or any other person or organization that received the payment must refund the applicable benefit plan if all or some of the expense:

- Did not legally have to be paid;
- Exceeded the benefits under the benefit plan; or
- Was paid by a source other than the benefit plan (i.e. claim for an illness or injury that someone else is legally responsible to pay). *(See the "Subrogation and Reimbursement"* subsection for further details.)

If you or the person or organization that was paid does not refund the full amount, the benefit plan may reduce the amount of any future benefits payable.

HIPAA Privacy

In General

The Department of Health and Human Services has issued Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), effective April 14, 2003, that govern the manner in which the group health plans (for purpose of this subsection, the "Plans") must handle Protected Health Information. "Protected Health Information," means individually identifiable health information related to a Covered Employee or Dependent.

Permitted Uses and Disclosures

The Plans may use and disclose Protected Health Information to carry out payment and health care operations without consent or authorization. If the Plans must use and disclose Protected Health Information for purposes other than payment or health care operations, patient authorization for such use or disclosure shall be required, unless such use or disclosure is expressly permitted by the Policies and Procedures Regarding Protected Health Information related to the Plans or the Privacy Standards.

Disclosures to Company

The Plans may disclose Protected Health Information to the Company to the extent that such disclosure is permissible under law, but prior to any such disclosure the Company shall certify that (1) the Plans documents have been amended as required by the Privacy Standards and (2) the Company has agreed to certain conditions set forth in the Privacy Standards regarding the use and disclosure of that Protected Health Information.

Adequate Separation

There shall be adequate separation between the Plans and the Company to help ensure that only persons involved in Plan administration have access to Protected Health Information. Only members of the Benefits Administration Department and the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee shall have access to Protected Health Information created under the Plans. Access to and use by such employees shall be restricted to the Plan administration functions that the Company and its affiliates perform for the Plans. The Plans or the Company (or an affiliate) has retained one or more third party administrators and others that receive Protected Health Information in the ordinary course of business performed on behalf of the Plans. Such persons or entities, known in the Privacy Standards as "Business Associates," shall enter into agreements with the Plans governing their obligations under the Privacy Standards.

Unauthorized Use or Disclosure.

The improper use or disclosure of Protected Health Information by an employee of Company (or an affiliate) shall be governed by the Policies and Procedures Regarding Protected Health

Information related to the Plans. The terms of the applicable Business Associate Agreement shall address non-compliance with the Privacy Standards by a Business Associate.

Employment Rights Not Guaranteed

Your participation in the Program or any benefit plan does not ensure you of continued (or renewed) employment with the Company or a Participating Employer. It also does not ensure your rights to benefits, except as specified under the terms of the Program. This Handbook is not a contract of employment.

Amendment and Termination

Subject to the terms of any applicable collective bargaining agreement, the Company, through resolution of the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee ("Committee"), may amend the benefit plans at any time. Although, it is the Company's intention that the benefit plans continue, the Company reserves the right to terminate any benefit plan, through resolution of the Committee, at any time without the consent of or advance notice to you or your covered dependents.

Named Fiduciary and Plan Administrator

The Company is the "Named Fiduciary" and "Plan Administrator" as defined in ERISA, and, as such, the Company has authority to control and manage the operation and administration of the benefit plans.

The Plan Administrator or its delegate has complete discretionary authority to make all determinations under the benefit plans, including eligibility for benefits and factual determinations, and to interpret the terms and provisions of the benefit plans. The Plan Administrator or its delegate has full discretionary authority to: interpret the benefit plans and construe the benefit plans terms; determine eligibility for and the amount of benefits; determine the status and rights of employees, dependents and other persons; make rulings; make regulations and prescribe procedures; gather needed information; prescribe forms; exercise all of the power and authority contemplated by ERISA and the Internal Revenue Code with respect to the benefit plans; employ or appoint persons to help or advise in any administrative functions; and generally do anything needed to operate, manage and administer the benefit plans. The Plan Administrator or its delegate has the requisite discretionary authority and control over the benefit plans to require deferential judicial review of its decisions as set forth by the United States Supreme Court in Firestone Tire & Rubber Co. v. Bruch. The Plan Administrator has delegated certain authority to the NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee ("Committee"), the NiSource Benefits Administration Department and third party administrators. To the extent not retained by the Committee, the Committee has delegated to the Claims Administrator the discretionary authority to:

- Make decisions regarding the interpretation or application of benefit plan provisions;

- Make determinations (including factual determinations) as to the rights and benefits of employees and participants under the benefit plans;
- Make claims determinations under the benefit plans; and
- Decide the appeal of denied claims.

Other authority may be delegated to the extent allowed by ERISA.

Benefits will be paid under the benefit plans only if the Plan Administrator or its delegate determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

The Role of the Claims Administrator

With respect to the benefit plans that are self-insured (as indicated in the *"General Program Information"* subsection of this **Overview**), the Company has retained a Claims Administrator to provide claim payment and other administrative services to such plans. Even though an employee may receive a benefit check from a Claims Administrator, the Company, a Participating Employer or another plan funding vehicle actually pays benefit claims; the Claims Administrator does not pay claims out of its pocket. Although the Claims Administrator may have insurance coverage as part of its business, the Claims Administrator is not an insurer in relation to the self-insured plans. The self-insured plans are funded from the general assets of the Company or the Participating Employer or another lawful funding vehicle that is in place, such as a Voluntary Employees' Beneficiary Association Trust.

With respect to the fully insured benefit plans, the Claims Administrator is also the plan's insurer.

Statement of ERISA Rights

As a participant in a benefit plan maintained by NiSource Inc., employees are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all plan participants shall be entitled to:

Receive Information about Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the benefit plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the benefit plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the benefit plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the benefit plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for you, your spouse or dependents if there is a loss of coverage under the benefit plan as a result of a qualifying event. Your or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the benefit plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the benefit plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 2 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for benefit plan participants; ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate the benefit plan, called "fiduciaries" of the benefit plan, have a duty to do so prudently and in the interest of the employee and other benefit plan participants and beneficiaries. No one, including your

employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, they have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of benefit plan documents or the latest annual report from the benefit plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that benefit plan fiduciaries misuse the benefit plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the employee is successful, the court may order the person the employee has sued to pay these costs and fees. If the employee loses, the court may order them to pay these costs and fees, for example, if it finds the employee's claim is frivolous.

Assistance with Questions

Questions regarding the benefit plan should be directed to the Plan Administrator. If there are questions about this statement or about your rights under ERISA, or if as an employee you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Program Information

Program Name:	NiSource Inc. Benefits Program
Benefit Plan Names:	NiSource Consolidated Flex Medical Plan NiSource Dental Plan NiSource Flexible Benefits Plan NiSource Vision Plan NiSource Short-Term Disability Plan NiSource Long-Term Disability Plan NiSource Travel Accident Plan NiSource Life and AD&D Plan
Type of Plan:	Group Health Plan – Medical, Dental, Flexible Spending Arrangements, Vision, Disability and Life and AD&D
Plan Sponsor:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 853-5200
Plan Administrator:	NiSource Inc. 801 East 86th Avenue Merrillville, Indiana 46410 (219) 853-5200
EIN:	35-2108964
Plan Year:	January 1 through December 31
Contributions:	As a condition of participation, participants will be required to contribute toward the cost of the benefit plan coverage they select in an amount determined by the Plan Administrator from time to time. The balance of benefit plan coverage cost will be paid by the Participating Employers or any other benefit funding vehicle as may be established or maintained from time to time.
Type of Administration:	Claims are administered by the Claims Administrators listed below under a contract between the benefit plan and the Claims Administrator. Benefits will be paid under a benefit plan only if the Plan Administrator, or its delegate (e.g., Claims Administrator), determines that the claimant is entitled to them.

Agent for Service of Legal Process: NiSource Inc.
801 East 86th Avenue
Merrillville, Indiana 46410
(219) 853-5200

Plan	Plan Type	Plan Number	Claims Administrator (and Insurer with respect to self-insured plans)	Type of Funding	Contribution Source
PPO – BlueCross and BlueShield; Standard Plan 1; Standard Plan 2;	Group Health Plan - Medical	501	Anthem Insurance Companies Inc. P.O. Box 37010 Louisville, KY 40233 www.anthem.com	Self- Funded	Employee and Employer
Prescription Drug	Group Health Plan – Prescription Drug	501	Walgreens Healthcare Plus 7357 Greenbriar Pkwy Orlando, FL 32819-8917 www.walgreenshealth.com 1-800-265-1807 (mail order) 1-800-749-0009 (mail order refill)	Self-Funded	Employee and Employer
Dental (Basic and Dental Plus)	Group Health Plan - Dental	507	CIGNA P.O. Box 188036 Chattanooga, TN 37422-8036 www.cigna.com	Self- Funded	Employee and Employer
Vision Service Plan (VSP)	Group Health Plan - Vision	509	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 www.vsp.com Claims- Non VSP provider Vision Service Plan P.O. Box 997105 Sacramento, CA 95899-7105	Fully-Insured	Employee and Employer
Life and AD&D	Life	503	The Prudential Insurance Company of America Group Life Services P.O. Box 907 Horsham, PA 19044-9868 www.prudential.com	Fully-Insured	Employee and Employer
Travel Accident Insurance	Life	513	NiSource Corporate Services Company Benefits Department 801 E 86th Avenue Merrillville, IN 46410	Self-Funded	Employer
Short-Term Disability	Disability	504	ESIS Two Riverway Suite 1100 Houston, TX 77056	Self-Funded	Employer

Plan	Plan Type	Plan Number	Claims Administrator (and Insurer with respect to self-insured plans)	Type of Funding	Contribution Source
Long-Term Disability	Disability	510	The Prudential Insurance Company of America P.O. Box 907 Horsham, PA 19044-9868 www.prudential.com	Fully-Insured	Employee and Employer
Health Care Flexible Spending Account	Pre-Tax Payment of Medical Expenses	511	FlexBen Corporation 2250 Butterfield Drive Suite 100 Troy, MI 48084 www.flexben.com	Not Applicable	Employee
Dependent Care Flexible Spending Account	Pre-Tax Payment of Dependent Care Expenses	512	FlexBen Corporation 2250 Butterfield Drive Suite 100 Troy, MI 48084 www.flexben.com	Not Applicable	Employee

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NiSource Travel Accident Plan

Summary Plan Description (SPD)

DRAFT DOCUMENT FOR DISCUSSION PURPOSES ONLY

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Your Travel Accident Benefit

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This plan covers eligible employees for accidental death sustained during the course of a business trip made on behalf of the Company.

The trip will be considered as commencing when you leave your residence or place of employment, whichever you leave last, for the purpose of going on such trip, and the trip will continue until you return to your residence or place of regular employment, whichever you return to first.

All eligible employees are covered for $50,000 in death benefits.

Eligibility & Enrollment

You will be automatically covered under the NiSource Travel Accident Plan (the "Plan") on the first day of your active employment with a Participating Employer (as defined in the **Overview**) if you are:

- A regular full-time employee of a Participating Employer who regularly works 40 or more hours per week; or

- A regular part-time employee of a Participating Employer who regularly works 10 or more, but less than 40, hours per week

For purposes of the Plan, you will be considered actively employed if, for each day that is one of the Participating Employer's scheduled workdays, you perform all of the regular duties of your job for such day. You will be deemed to be actively employed on any day that is not one of the Participating Employer's scheduled workdays only if you were considered to be actively employed on the preceding workday.

If you meet these eligibility requirements, you will automatically be enrolled in the Plan.

Information regarding eligibility can be access through MySource Web site at www.myshourforhr.com or by calling the MySource automated telephone system at 1-888-640-3320 to speak to a service representative.

When Coverage Begins and Ends

Coverage Begins

Generally, coverage under the Plan may become effective on your first day of active employment for regular new hires.

Coverage Ends

You will cease to participate in the Plan on the earliest of the following:

- The date as of which the Plan is terminated;
- The date that the Plan is amended to terminate your coverage;
- The end of the month following the date you are no longer eligible for coverage under the Plan;
- The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided in the NiSource Military Leave of Absence Policy; and
- The date you terminate employment.

Beneficiary Designation

Your beneficiary will be the beneficiary or beneficiaries that you named under the NiSource Life Insurance Plan. (Please see the "*NiSource Life and AD&D Plan SPD*" section of this handbook for further details on beneficiary designation.)

If you fail to designate a beneficiary before your death, or if your beneficiary dies before you die, the benefits are paid to the first of the following:

- Your spouse, or if none are living;
- Your lawful descendents (divided proportionally), or if none are living;
- Your estate, or if none is appointed within six months of your death;
- Your heirs under the laws of the state in which you were domiciled on the date of your death.

You and your beneficiary need to keep the Company advised of the addresses at which each of you can be located. If the Company cannot locate you or your beneficiary when benefits become payable, notification will be mailed to the most recent address on file. The Claims Administrator is not required to search for, or locate, you or your beneficiary. Please be sure to notify MySource for Human Resources should you or your beneficiary change addresses.

If a beneficiary becomes entitled to a payment under the Plan and it cannot be made because (1) the current address is incorrect, (2) the beneficiary does not respond to the notice sent to the current address, (3) there are conflicting claims to such payment, or (4) any other reason, the amount of such payment, if and when made, shall be that determined under the terms of the Plan, without interest.

To designate or change your beneficiary(ies) go online via the MySource for Human Resources Web site or call MySource for Human Resources toll-free number at 1-888-640-3320 to speak with a customer service associate.

Travel Accident Benefit Exclusions

The Plan does not cover any accidental death incurred due to:

- Commuting to and from work, and any travel during lunches, breaks and vacations;
- Suicide or any attempted suicide while sane or self-destruction or an attempted suicide while insane;
- Declared or undeclared war or any act of either within the United States, the District of Columbia or Canada;
- Service in the armed forces of any country; provided, however, orders to active military service for two months or less will not constitute service in the armed forces; or
- Sickness or disease, except infections that occur through an accidental cut or wound.

Filing a Claim

In the event of death or covered loss, you or your beneficiary must contact the NiSource Benefits Administration Department at 801 E. 86th Avenue, Merrillville, Indiana 46410 within 31 days or as soon as reasonably possible in order to receive benefits.

The Plan pays benefits based on the coverage that was in effect on the date of your death. The benefit is paid in the form of a lump-sum payment.

Claim Denial Process

Consideration of Initial Claim

Within 90 days of receiving a claim, the Claims Administrator will provide your beneficiary with a written notice of its decision. If because of special circumstances, the Claims Administrator cannot provide a decision within the 90-day period, the Claims Administrator can extend the period to up to 180 days (the 180-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 90-day period. The notice will include the special circumstances requiring the extension.

If the Claims Administrator Denies the Claim

If the Claims Administrator denies your beneficiary's claim in whole or in part, your beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the pertinent provisions in the Plan on which the denial is based;
- A description of any additional material or information necessary for your beneficiary to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's review procedures.

Claims Review Process

Appeal to Claims Administrator

If your beneficiary has a claim denied in whole or in part, your beneficiary has the right to appeal the decision to the Claims Administrator by sending a written request for review within 60 days of the claim denial.

Upon receipt of your beneficiary's letter, the claim will be reviewed. Your beneficiary will normally be notified of the results of this review within 60 days. If because of special circumstances, the Claims Administrator cannot provide a decision within the 60-day period, the Claims Administrator can extend the period to up to 120 days (the 120-day period begins on the date the written claim is received). The Claims Administrator will provide your beneficiary with a written notice of the extension before the end of the initial 60-day period. The notice will include the special circumstances requiring the extension.

If the Claims Administrator denies your beneficiary's claim in whole or in part, your beneficiary will be provided with written notice of the denial. Such notice shall be written in a manner calculated to be understood by your beneficiary and shall include:

- The specific reason or reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A description of any additional material or information necessary for your beneficiary to perfect the application and an explanation of why such material or information is necessary; and
- An explanation of the Plan's review procedures.

If the decision of the Claims Administrator is not furnished within 60 days after its receipt of the appeal, or within 120 days of receipt of such appeal if the Claims Administrator gives notice in writing that an extension of time is required for processing the claim, the appeal to the Claims Administrator shall be deemed denied.

Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your beneficiary's claim on appeal, your beneficiary may file a written claim with the Plan Administrator within 60 days after your appeal has been denied in whole or in part by the Claims Administrator.

Any claim for benefits with the Plan Administrator will be processed within 60 days of its receipt unless additional time is required to process the claim, in which event your beneficiary will be notified that an additional period of 60 days is required to process the claim.

If your beneficiary's claim for benefits is denied in whole or part by the Plan Administrator, written notice of the decision to deny such application will be promptly furnished to your beneficiary within 60 days after receipt of the claim for benefits, or within 120 days of receipt of such claim if the Plan Administrator gives notice in writing that an extension of time is required for processing the claim. Each notice of denial of an application shall be in writing and shall contain the following information:

- The specific reason or reasons for the denial;
- Specific references to the Plan provisions upon which the denial is based;
- A description of any additional material or information necessary for your beneficiary to perfect the application and an explanation of why such material or information is necessary; and
- An explanation of the Plan's review procedures (as described below).

Second Appeal to the Plan Administrator

In the event the Plan Administrator upholds the claim denial in whole or in part, your beneficiary may request a review of such denial by the Plan Administrator. Each such request for review must be in writing signed by your beneficiary, must specify that it is a request for review of a denied claim and must be filed with the Plan Administrator no later than 60 days after receipt of the denial or 90 days after the claim is deemed to be denied because the Plan Administrator did not respond within the requisite time period.

The decision of the Plan Administrator upon a request for review shall be made within 60 days after the request for review is received by the Plan Administrator unless special circumstances require an extension of time for processing such review, in which event your beneficiary shall be notified in writing prior to the expiration of such 60 days, and the decision of the Plan Administrator shall be rendered within 120 days of the receipt of the request for review. In connection with a request for review, your beneficiary may submit issues and comments in writing to the Plan Administrator. All communications between the Plan Administrator and your beneficiary shall be in writing unless your beneficiary requests otherwise and the Plan Administrator consents thereto. Each decision of the Plan Administrator on a request for review shall be in writing and shall include:

- The specific reason or reasons for the decision;
- Specific references to the Plan provisions upon which the decision is based; and
- A description of any additional material or information necessary for your beneficiary to perfect the claim and an explanation of why such material or information is necessary.

Contact Information

If you need answers to specific coverage related questions, contact MySource for Human Resources by going to their Web site or using their automated telephone system. Both the Web site and the automated telephone system can connect you with the Claims Administrator.

For…	Contact…
Travel Accident Benefit Information	NiSource Corporate Services Benefits Administration Department www.mysourceforhr.com (link to www.prudential.com) 1-888-640-3320 (MySource for Human Resources) You can connect with the Claims Administrator by phone via the MySource for Human Resources automated telephone system

General Plan Information

The Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974).

Plan Type:	Travel Accident
Plan Number:	533
Claims Administrator:	NiSource Corporate Service Company Benefits Administration Department 801 E. 86th Avenue Merrillville, IN 46410
Type of Coverage:	Self Funded
Contribution Source:	Employer

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NiSource Vision Plan

Summary Plan Description (SPD)

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Your Vision Plan Options

NiSource Inc. (the "Company") provides eligible employees and their dependents with the option to elect coverage under the NiSource Vision Plan (the "Vision Plan" or "Plan"). This Plan is designed to cover certain costs associated with your vision correction. Please note any illness or injury to your eyes would be covered under the Medical Plan.

The Plan utilizes a network of VSP doctors. You also have the option to receive benefit coverage from non-VSP providers. However, your level of benefit coverage will be reduced from the level of coverage you would be eligible to receive if you utilized a VSP network doctor. The Plan pays vision benefits for eligible expenses regardless of whether you receive services and eyewear from a VSP network doctor or a non-VSP provider. However, if you go to a VSP network doctor, the Plan pays a higher level of benefits (and you do not have to file a claim).

- **VSP Network Doctor**—offers the convenience of "one-stop shopping" and can provide everything you need (eye exams, prescription glasses, and contacts). As long as you receive care and eyewear from a VSP network doctor, you are responsible for the amount in excess of the Plan's allowance, or the cost of any eyewear or service that the Plan does not cover.

- **Non-VSP Providers**—you have the option to receive your services and eyewear outside the network. If you do, you must pay the provider in full at the time of your appointment and submit a claim to VSP. Once you submit an itemized receipt, the Plan then reimburses you for the eligible expense (up to the Plan's allowance).

To find a doctor who participates in the VSP Network, log on to the MySource for Human Resources Web site at www.mysourceforhr.com or call MySource at 1-888-640-3320 to request assistance. .

Highlights of Your Vision Plan Coverage

The Vision Plan pays for the following services and materials:

Covered Services	Frequency	VSP Network Doctor	Non-VSP Provider
Exam	Once every 12 months	100%	Up to a $35 Allowance
Lenses (per pair)			
• Regular (single vision)	One every 12 months	100%, Up to the Lens Allowance	Up to a $25 Allowance
• Lined Bifocal	One every 12 months	100%, Up to the Lens Allowance	Up to a $40 Allowance
• Lined Trifocal	One every 12 months	100%, Up to the Lens Allowance	Up to a $55 Allowance
•			
Frame	One every 24 months	100%, Up to a $180 Frame Allowance.	Up to a $45 Allowance
Contacts	One every 12 months (in place of glasses)	100%, Up to $150 Annual Allowance	Up to a $105 Allowance

If you choose contacts instead of glasses, your $150 allowance applies to the cost of your eye exam, contacts and contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

Eligibility

You and your eligible dependents can elect to participate in the Vision Plan provided you are actively at work and you fall under one of the categories set forth below.

- A regular full-time employee of a Participating Employer (as defined in the **Overview**) who regularly works 40 or more hours per week;

- A regular part-time employee of a Participating Employer, who regularly works 10 or more, but less than 40 hours per week.

Your eligible dependents include:

- Your lawful spouse, if you are not legally separated;

- Your child who: (1) is less than 19 years old*; or (2) is 19 years but less than 25 years old and attends an educational institution full-time (i.e. accredited college or university, or a vocational or trade school, that is fully licensed (by the state, if required) or has at least one student who is eligible to receive government-sponsored loans or grants);

- Your child who is incapable of self-sustaining employment due to mental or physical disability if: (1) proof of the child's disability, if requested by the Claims Administrator, is received by the Claims Administrator within 31 days of the date dependent status would otherwise terminated, (2) the child is dependent upon the employee for financial support and maintenance, (3) the employee continues to be covered by the Plan, and (4) the child's disability continues; and

- Your child who is recognized under any court order, including a Qualified Medical Child Support Order that is recognized as legally sufficient, as having a right to participate in the Plan as a dependent.

If one or more of your covered dependents is a college student (age 19 or up to their 25th birthday), you need to verify that your dependent is a full-time student** each year **through MySource at 1-888-640-3320.* ***Information regarding eligibility can be access through MySource Web site at www.myshourforhr.com or by calling the MySource automated telephone system at 1-888-640-3320 to speak to a service representative.

Enrollment

Provided you meet the eligibility requirements, as described in the "*Eligibility*" section of this Vision Plan SPD, you and your eligible dependents can participate in the Plan if you properly enroll. Newly eligible employees must enroll within 31 days of their eligibility date. In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire plan year and can only be changed during annual open enrollment period. However, if you experience a qualified life event, you may enroll or change existing coverages during the year. (Please see the "*Enrollment*" section of the **Overview** and the "*Changing and Continuing Your Coverages*" section of the **Overview** for further details).

If you fail to enroll, you and/or your dependents will not receive any coverage. If you decline coverage or fail to enroll under the Plan, you cannot re-enroll for two years. This means that you can re-enroll during the annual enrollment period after you satisfy the two-year rule.

When Coverage Begins and Ends

Coverage Begins

Generally, coverage under the Vision Plan may become effective (i) on your first day of active employment for a regular new hire, (ii) on the first day of the following plan year for eligible employees who enroll during the annual enrollment period, or (iii) on the date of the qualified life event for eligible employees who enroll due to such qualified life event. Eligible dependents have the same effective date, provided you properly enroll them.

Coverage Ends

Your coverage under the Plan ends as follows:

- The date as of which the Plan is terminated;
- The date that the Plan is amended to terminate coverage with respect to an employee;
- The end of the month following the date an employee is no longer eligible for coverage under the Plan;
- The date an employee commences active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 and except as provided in the NiSource Military Leave of Absence Policy;
- The last date for which any required contribution was made;
- The date on which a leave of absence begins, except to the extent continuation coverage is required by the Family Medical Leave Act of 1993; or
- The end of the month following the date an employee terminated employment.

A dependent shall cease to participate in the Plan on the earliest of the following dates:

- The date as of which the Plan is terminated;
- The date the employee's coverage ends;
- The last date for which any required contributions for the dependent's coverage were made; or

- The end of the month following the date the dependent no longer qualifies as a dependent.

Expenses Covered

The Vision Plan will pay for vision services and materials, as described in the "*Highlights of Your Vision Plan Coverage*."

The services and materials that the Plan covers include, but are not limited to, the following:

- One vision exam in every 12-month period.
- Prescription eyeglass lenses, one pair in every 12-month period, up to a specified lens allowance.
- Frame, one pair in every 24-month period (up to the frame allowance). Plus, 20% off any out-of-pocket costs of frames from a VSP doctor. You must pay for anything in excess of the allowance.
- Contacts, one pair in every 12-month period, up to a specified allowance. The allowance applies to the cost of your eye exam, contacts and contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of your contacts. You can elect to receive an annual allowance toward the cost of contacts in lieu of lenses.

Extra Discounts and Savings

When visiting a VSP network doctor, you will receive:

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.
- 20% off additional prescription glasses and sunglasses.
- 15% discount off the cost of contact lens exam (fitting and evaluation).
- Polycarbonate lenses are covered in full for dependent children
-
- Laser vision correction discounts.

Other Programs/Resources Offered by the VSP

Laser VisionCare℠ Program

If you are considering laser vision correction, the Plan can help you make an informed decision. The Plan contracts with many of the nation's finest laser surgery facilities and doctors. As a result, you can access laser vision correction surgery for hundreds of dollars less than what you might pay privately. VSP has arranged for members to receive PRK, LASIK and Custom LASIK at a discounted fee. Visit the Claims Administrator's Web site at vsp.com or call 1-800-877-7195 to learn more about this program.

To confirm if an expense is eligible for reimbursement, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Expenses Not Covered

The Vision Plan pays benefits for many vision care services and eyewear. However, some limits and exclusions do apply. If you want to know if a service or eyewear will be covered under the Plan, or if you have questions regarding your coverage, please ask your VSP doctor or call the Claims Administrator.

Patient Options

This Plan is designed to cover visual needs rather than cosmetic eyewear. When a Covered Member selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Member will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitates on low vision care.

How Your Health Care Flexible Spending Account Can Help

Remember, you can use your Health Care Flexible Spending Account to pay for eligible vision care expenses that are not covered under the Vision Plan. You also can use the Health Care Flexible Spending Account to reimburse yourself for your share of the cost of any vision care services (i.e., any amounts that exceed the plan's specified allowances). You must submit eligible expenses to the health care flexible spending account no later than the March 31st following the plan year in which you incurred the expense. Please see the "*FSA Plan*" section of this handbook for additional details about the Health Care Flexible Spending Account.

Not Covered

There are no benefits for professional services or eyewear connected with:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (less than a +.38 diopter power).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an experimental nature.
- Costs for services and/or eyewear above Plan Benefit allowances.
- Services and/or eyewear not indicated on this Schedule as covered Plan Benefits.

Coordination of Benefits (COB)

If you or your dependents have vision coverage under another vision plan, the primary plan is the one under which you are covered as an employee. Eligible dependent children receive primary coverage under their father's plan.

If your secondary plan pays the out-of-pocket expenses you incur under your primary plan, the following rules apply:

- The deductible (if any) under the secondary plan is waived;
- Payment under the secondary plan is made directly to you (according to the secondary plan's non-network provider schedule); and
- Any payment made toward a service or material that is covered under the secondary plan exhausts the secondary plan's coverage for that service for the entire benefit period.

If the primary plan already pays for a service or eyewear within the allowed period and you use a VSP network doctor (in-network) under the secondary plan for that same service, the service is provided based on the secondary plan's preferred care provider schedule. In this case, deductible amounts (if any) toward that service apply under the secondary plan.

If you have primary coverage under another carrier, the Vision Plan provides secondary coverage based on the coordination of benefits rules outlined in the "*Coordination of Benefits*" section of the **Overview**.

If you do not use the secondary plan to recover out-of-pocket expenses incurred under the primary plan, you can use the secondary plan for another claim (provided such services have been exhausted under the primary plan).

How to Access The Vision Benefits

Selecting a VSP Network Doctor

- Log on to the MySource for Human Resources Web site at www.mysourceforhr.com to find the link to VSP's Web site that houses the most up-to-date list of VSP network doctors; or call MySource for Human Resources at 1-888-640-3320 to locate a VSP network doctor near you.Call the VSP network doctor to make an appointment. Identify yourself as a VSP member.

- At the time of the visit, pay any amounts that are in excess of the allowance or the Plan's covered services. The VSP network doctor files all necessary claims directly from his or her office. The Claims Administrator takes care of all of the necessary paperwork, and pays the doctor directly for the eligible expenses.

If you select a NonVSP Provider

If you receive care from a non-VSP provider, you are required to submit a claim form. Here are the steps to follow when filing your own claim with the Claims Administrator:

- Complete your portion of the claim form. Forms can be obtained from the Claims Administrator. You can connect with the Claims Administrator via the MySource for Human Resources Web site (www.mysourceforhr.com) and link to the Claims Administrator's Web site..

- Attach copies of your itemized bill and paid receipts to your claim form. These bill should include:

    - Name of patient;
    - Patient's relationship to you;
    - Patient's date of birth;
    - Name and Social Security number of employee;
    - Provider's bill; and
    - Copy of your itemized paid receipt (you can forward this to the Claims Administrator without a completed claim form as long as you include your name and social security number, the patient's name and relationship to you, and the patient's date of birth).

Submit your completed claim form to the Claims Administrator. Claims should be submitted to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Be sure to submit your completed claim to the Claims Administrator within six months of the date of your service.

Your claim will be processed upon receipt.. The Plan then pays eligible benefits directly to you. Regardless of whether you receive care from a VSP network doctor or a non-VSP provider, you receive a statement that tells you how much the Plan paid. In some cases, the Claims Administrator sends the payment to a designated representative (as in the case of a Qualified Medical Child Support Order).

If you have a claim inquiry or a question regarding filing claims, call the Claims Administrator via MySource for Human Resources at 1-888-640-3320.

Claim Denial and Appeal Process

The Claims Administrator may establish a claim denial and appeal process. In the event the Claims Administrator does not do so, or if such process fails to comply with applicable law, the procedures set forth below will apply.

The type of claim that you make determines the time frame under which the Claims Administrator makes a determination regarding your claim. There are four different categories of claims, and each is subject to different time frames for notifying you of the Claims Administrator's determination.

Consideration of Initial Claim

Pre-Service Claim (Not Involving Urgent Care)

Generally, a "pre-service claim" is any claim involving a benefit where the Plan requires approval of the benefit in advance of obtaining medical care.

If you submit a pre-service claim properly with all necessary information, the Claims Administrator decides your claim within a reasonable period of time appropriate to the medical circumstances (but not later than 15 days from the date the claim is received). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to expiration of the initial 15–day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you file a pre-service claim improperly, you receive a notice of the improper filing and how to correct it within five days after your pre-service claim is received. Once you receive notice, you then have 45 days to provide any needed information. If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Outline the claims appeals process.

Post-Service Claims

If you submit a post-service claim, you will receive a written notice of the Claims Administrator's determination within 30 days of the day the Claims Administrator receives your claim (as long as you provide all necessary information). The Plan may request a one-time extension (not longer than 15 days) for matters beyond its control if, prior to the expiration of the initial 30-day period, the Claims Administrator notifies you of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If additional information is needed to process your post-service claim, you are notified within the 30-day period and the notice will specify the required information. Once you receive notice, you then have 45 days to provide any needed information. If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Outline the claims appeals process.

Urgent-Care Claims

Generally, an "urgent care claim" is any claim that must be processed on an expedited basis because a delay in processing could seriously jeopardize the life or health of the patient or, in the opinion of the patient's doctor, a delay would subject the patient to severe pain.

You receive notice of the benefit determination (in writing or electronically) within 72 hours after the Claims Administrator receives all necessary information. The Claims Administrator takes into account the seriousness of your condition. The Claims Administrator may provide an oral notice of its determination, and then follow up with a written or electronic confirmation within three days.

If you file an urgent-care claim improperly, you receive a notice of the improper filing and how to correct it within 24 hours after the Claims Administrator receives your urgent–care claim. Once you receive this notice, you then have 48 hours to provide the requested information. You receive a notice of the Claims Administrator's determination no later than 48 hours after the earlier of:

- The day the Plan receives the requested information; or

If You Have Questions

If you have a question or concern regarding a benefit determination, contact the Claims Administrator or the MySource Participant Advocacy service through the MySource for Human Resources toll-free number (1-888-640-3320) before you request a formal appeal. If you are not satisfied with a benefit determination, you can appeal it.

- The end of the period that you have to provide the specified additional information.

If you receive a denial notice, the notice will:

- Explain the reasons for the denial;
- Describe any additional material or information necessary for you to complete your claim and explains why the material or information is necessary;
- Refer you to the part of the Plan upon which the denial is based; and
- Outline the claims appeals process.

Concurrent-Care Claims

The Claims Administrator may approve (for a specific period of time or number of treatments), reduce, or terminate an ongoing course of treatment. Any reduction or termination of ongoing treatments is an adverse benefit determination. The Claims Administrator must notify you within a reasonable time period prior to the reduction or termination of services.

If you request to extend the treatment and your request meets that of an urgent care claim (as defined above), the Claims Administrator decides your request within 24 hours after it receives your request. You must make your request at least 24 hours before the end of your approved treatment.

If your request to extend ongoing treatment does not involve urgent care, the Claims Administrator treats your claim as either a pre-service or post-service claim (as applicable and considers the claim according to the post-service or pre-service time frames; whichever applies.

Appeal to Claims Administrator

If your initial claim is denied in whole or in part (as described above), you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the claim denial notification.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your

authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford any deference to the initial adverse benefit determination and will be conducted by an individual who is neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual.

If the denial was based in whole or in part on a medical judgment, the individual conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Claims Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Claims Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

Expedited Review for Urgent Care Claims

In the case of a claim involving urgent care, you may submit a request for an expedited appeal either in writing or orally. All necessary information for the review, including the Claims Administrator's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or another similarly expeditious method. The Claims Administrator will notify you of its determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination.

If the Claims Administrator Denies Your Claim on Appeal

If the Claims Administrator denies your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and

- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If the Claims Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided free of charge to you, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the Claims Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided free of charge to you, or you will be informed that such explanation will be provided free of charge to you upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Second Appeal to the Plan Administrator for Pre and Post Service Claims

If the Claims Administrator denies all or any portion of your pre or post service claim on appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator by sending a written request for review to the Plan Administrator within 180 days of your receipt of the Claims Administrator's notice of claim denial.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your written request, you will be provided, free of charge, reasonable access to, and copies of, all relevant documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include the name of your employer, any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted

or considered in the initial benefit determination. The review will not afford any deference to the Claims Administrator's denial of your claim on appeal.

If the denial was based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional consultant will be neither the individual who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such individual. The Plan Administrator will provide the identities of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Pre-Service Claims

In the case of a pre-service claim, the Plan Administrator will notify you of its determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of your request for review.

Post-Service Claims

In the case of a post-service claim, the Plan Administrator will notify you of its determination on review within a reasonable period of time, but not later than 30 days after receipt of your request for review.

If the Plan Administrator Denies Your Claim on Appeal

If the Plan Administrator denies your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If the Plan Administrator relied upon an internal rule, guideline, protocol, or other similar criterion in making the adverse determination, either the specific rule, guideline, protocol, or

other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

If the Plan Administrator relied upon medical necessity or experimental treatment or similar exclusion or limit in making the adverse determination, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances) will be provided to you free of charge, or you will be informed that such explanation will be provided to you free of charge upon request.

In addition, the notice will include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Continuation of Coverage and COBRA Coverage

Continuation of Coverage

Generally, coverage under the Vision Plan is only available to you if you are actively at work. However, there are certain leaves during which you can continue your coverage. They are:

Short Term Disability ("STD") Leave – Vision coverage for you and your eligible dependents continue while you are receiving STD benefits or if an appeal process is pending in accordance with the provision of the STD Plan. Your contributions for the vision coverage will continue to be deducted from your check.

Long Term Disability ("LTD") Leave – Vision coverage for you and your eligible dependents continue while you are receiving LTD benefits or if an appeal process is pending in accordance with the provision of the LTD Plan. You must continue to make your required contribution. .

Family Medical Leave (FMLA) – Vision coverage for you and your eligible dependents continues at the same level of contribution and under the same conditions as if you had continued in employment while you are on FMLA leave. In the event you are on FMLA leave, you must continue to pay your contribution for the Vision coverage..

Uniformed Services Employment and Reemployment Rights Act (USERRA) – If you are absent from employment because of service in the "uniformed services" (as that term is defined by USERRA), you may elect to continue coverage under the Vision Plan during the period of your service to the extent provided in USERRA and the NiSource Military Leave of Absence Policy.

The Company may recover its cost of coverage if you exhaust your leave and do not return to active employment for reasons other than the continuation or onset of a serious health condition or other circumstances beyond your control. The Company may require you to provide certification of a health care provider if you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition.

COBRA Coverage

In the event your benefits under the Plan terminate, you may be eligible to continue your vision coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") provided you experience a COBRA qualifying event. Please see the "*Continuation of Benefits (COBRA)*" section of the **Overview** for further details.

Contact Information

Specific coverage related questions should be directed to MySource for Human Resources by going to their Web site or using their automated telephone system.

VSP	VSP www.mysourceforhr.com (link to vsp.com) 1-888-640-3320 (MySource for Human Resources) The *Claims Administrator* can be reached by phone via the MySource for Human Resources automated telephone system.

General Vision Plan Information

The Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974).

Plan Type:	Vision
Plan Number:	509
Claims Administrator/Insurer:	VSP 3333 Quality Drive Rancho Cordova, CA 95670 vsp.com
Claims Address for Non –VSP Provider:	VSP P.O. Box 997105 Sacramento, CA 95899-7105
Type of Insurance:	Fully-Insured. The Vision Plan is insured under a group contract underwritten by the Insurer.
Contribution Source:	Employee and Employer

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NiSource

Short-Term

Disability Plan
(including descriptions of
certain other special programs)

Summary Plan

Description (SPD)

DRAFT DOCUMENT FOR

DISCUSSION PURPOSES ONLY

Contents

Contents (continued)

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Your Short-Term Disability Plan

NiSource Inc. (the "Company") provides eligible employees with short-term disability ("STD") coverage at no cost to the employee. The company provides you with limited income continuation should you become Disabled and unable to work because of a short-term illness or injury.

You are considered "Disabled" or to have incurred a "Disability" if your illness (including pregnancy) or injury prevents you from performing your regular occupation (as described below).

How Your Paid Sick Leave Works

Each January 1st, after one year of employment, all eligible employees are granted 1040 hours of paid sick leave that is paid in accordance with the terms below. All absences due to illness or injury, regardless of duration, are deducted from your sick leave balance. If you use all of your paid sick leave time and you are still unable to return to work, you will be on a leave of absence without pay. You may continue in this unpaid status until:

- You are eligible to receive Long Term Disability Plan Benefits;
- You return to work;
- You terminate employment; or
- You retire.

If you are still on sick leave at the end of December and you remain unable to work into the next calendar year, you continue to use remaining sick leave from the previous year. You do not receive credit for additional service until you return to work for one full day in the new year This means that your sick leave time will not increase while you are absent due to illness or injury .

Categories of Disability

For STD Plan benefit purposes, there are different types of Disabilities for which you may qualify. They are defined as follows:

Total Disability

You are considered Totally Disabled if you are mentally or physically unable to perform any of the essential functions of your occupation or any job requiring similar education or training that a Participating Employer (as defined in the **Overview**) offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case, you must be under the regular care of a qualified physician* and furnish proof of your Disability to the Company or its representative.

INSERT DEFINITION FROM PLAN

Partial Disability

You are considered Partially Disabled if you are mentally or physically unable to perform, on a full time basis, the essential functions of your occupation or any job requiring similar education or training that a Participating Employer offers you, for which you are reasonably qualified because of your education, training, or experience. If this is the case, you must be under the regular care of a qualified physician* and furnish proof of your Disability to the Company or its representative. *Please Note: If you are Partially Disabled, you may be assigned temporary modified work. The temporary modified work assignment must be approved by your personal physician, the Company physician (where appropriate) and your supervisor.*

Please Note: If you require a professional license or certification for your occupation and you lose that license or certification, the loss (in and of itself) does not constitute a Disability under the Plan.

Recurring or Separate Periods of Disability – Meg to draft changes

Your STD Plan benefits begins once you are Disabled, up to a maximum period of 26 weeks.

If you are collecting STD Plan benefits, you temporarily recover, you return to work for the Company for 180 consecutive calendar days or less, and you then again become Disabled due to the same or a related illness or injury, the plan treats your subsequent Disability as a recurring Disability. This means that you will be entitled to benefits for the recurring Disability for the maximum benefit period, less the benefits you have already received for that Disability.

If you are collecting STD Plan benefits, you temporarily recover, you return to work for the Company for 181 or more consecutive calendar days, and you then again become Disabled due to the same illness or injury, the Plan treats your Disability as a separate Disability.

Eligibility and Enrollment

If you are a full time employee you will be eligible to participate under the Plan on the first day of the month coincident with or next following your completion of six continuous months of active service as an employee of a Participating Employer. You are a "full-time employee" if you regularly work 40 hours per week and for new hires, you must be Actively at Work on the date coverage is scheduled to begin.

This coverage is provided to you at no cost and requires no enrollment.

Your Disability rate of pay is determined by your credited service years. *Please see the "Highlights of Your Disability Plan Coverage" section for further details.*

Information regarding eligibility can be accessed through MySource Web site at www.mysourceforhr.com or by calling the MySource automated telephone system at 1-888-640-3320 to speak to a service representative.

When Coverage Begins and Ends

Coverage Begins

STD Plan coverage becomes effective on the first day following the date you complete six continuous months of active, full-time employment with a Participating Employer.

Coverage Ends

You will cease to be covered under the Plan for benefits on the earliest of the following:

- The date the Plan is terminated;
- The effective date of any Plan amendment that terminates coverage with respect to you;
- The date you are no longer eligible for coverage under the Plan –The date you commence active duty in the armed forces, except to the extent continuation coverage is required pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994;
- The last day for which you made any required contribution toward the cost of Plan coverage;
- The date you begin any leave of absence; and
- The date your employment terminates.

Highlights of Your Short-Term Disability Plan Coverage
If you become Disabled, your disability benefit is determined according to your length of service and can extend up to 26 weeks during a calendar year, for a related or recurring disability based on the following schedule:

Credited Years of Service	You Receive 100% of Your Base Salary For the First…	Then You Receive 60% of Your Base Salary For the Remaining…
Six months of Service to Less Than One Year of Service	1 Week (40 hrs)	0 Weeks
From One Year of Service to Less Than Ten Years of Service	8 Weeks(320 hrs)	18 Weeks-(720 hrs)
From Ten Years of Service to Less Than Twenty Years of Service	16 Weeks(640 hrs)	10 Weeks(400 hrs)
Twenty or More Years	26 Weeks(1040hrs)	0 Weeks

Your benefits may end prior to the periods set forth in this schedule for reasons described in the "When Benefits End" section.

Upon your first year anniversary, you are credited with one year of service and are entitled to receive benefits for the full benefit period of 26 weeks. You are credited with an additional year of service on the December 31 following your first anniversary and each subsequent December 31 thereafter.

To determine your STD Plan benefit, the Plan takes a percentage -of your Base Salary* . This is called your "gross STD Plan benefit." The Plan then deducts any "other sources of disability income" from this amount to determine your "net STD Plan benefit."

Special provisions apply and are described below if you are Partially Disabled and are able to perform a temporary modified work assignment.

*"Base salary" means your basic earnings plus any before tax deposits deferred under a qualified retirement plan of a Participating Employer. If you receive sales commissions, your Base Salary will be your average hourly wage based on the 12 consecutive calendar months immediately proceeding the last day you were actively at work.

Your Base Salary does not include:

- Overtime;
- Shift differentials;
- Bonuses; or
- Any other form of special compensation.

Other Sources of Disability Income

You may be eligible for income from other sources due to your Disability. If this is the case, your benefits under the Plan will be fully offset by such other sources of Disability income.

Other sources of Disability income for which you are eligible, or that have been paid to you or to a third party on your behalf may include, but are not limited to, the amount of any benefit for loss of income for the same Disability from:

- The United States Social Security Act, the Railroad Retirement Act, the Jones Act, or similar plan or act
- Any temporary or permanent disability benefits under a Workers' Compensation law (does not include permanent impairment award), occupational disease law, or similar law
- The Veteran's Administration or any other foreign or domestic governmental agency Any governmental law or program that provides disability or unemployment benefits as a result of your employment with a Participating Employer, including any state disability program;
- Disability benefits from any compulsory "no-fault" automobile insurance.

If you receive a benefit from another source of income in the form of a single lump sum, the amount of offset to the weekly benefit amount will be determined by prorating the lump sum over a period of 26 weeks.

State Disability Programs

If you work in a state that requires a state-defined disability plan, you are also covered under the provisions of the laws and regulations of that state plan. Your gross STD Plan benefit is reduced by the amount you are eligible to receive under any state disability program.

Applying for Other Sources of Disability Benefits

If you are eligible to receive disability benefits from other sources, you should apply as soon as possible. You should notify the Claims Administrator that you are eligible to receive other disability income as soon as possible.

When Benefits End

Your benefit payments will end as set forth in the schedule above, or sooner if any of the following events occur:

- You fail to submit evidence of your Disability or such other documents that the Plan deems necessary to administer the Plan, in accordance with Plan procedures;
- You do not comply with the Plan's request for evidence of your continuing Disability, an independent medical examination or other examinations or tests;
- You are engaged in any other occupation or earn any self-employment income in excess of a de minimis amount;
- You are not under the regular care of a physician as required by your condition or you are not following the physician's treatment plan;
- You participate in and are convicted of a felony offense. In such case, your Disability will be determined to have ceased as of the date that you first participated in the felony offense;
- You commit or partake in any actions of fraud against the Plan or a Participating Employer;
- You are no longer considered by the Plan to be Disabled;
- Your 26-week benefit period ends;
- You become eligible for LTD Plan benefits;
- You have been terminated or have voluntarily terminated employment with a Participating Employer (other than transfer to another Participating Employer); and,
- You die.

Claiming Benefits

If you are unable to work because of illness or injury, you must adhere to the following procedures to qualify for STD benefits:

- Call your supervisor before your normal work day begins. If that is not possible, be sure to contact your supervisor as soon as you can. If you cannot call in, please be sure that someone calls in on your behalf. *The Company may require that you provide a physician's statement confirming your illness or injury before your absence is actually approved.*

- If you are, or know you will be absent from work for more than four consecutive work days, call MySource for Human Resources at 1-888-640-3320 or the Claims Reporting Hotline at 1-877-ENERGY4, Option #2, then Option #2 again, to report your illness or injury to the Plan's Disability Management Program.

Disability Management Program

You must participate in the Disability Management Program to qualify for STD Plan benefits. The Disability Management Program certifies that you qualify for STD Plan benefits beyond the fourth day of absence. You will be assigned a "Claims Administrator" who will:

- Guide you through the disability benefits that may apply to your situation;

- Certify whether your disability qualifies for STD pay; and

- Help develop a reasonable return-to-work plan with you, your physician, and your supervisor.

You will be expected to participate fully in the Disability Management Program. You must:

- Supply the authorization and documentation as described in the following section;

- Maintain contact with your Claims Administrator;

- Follow the medical treatment plan that is agreed to by your Claims Administrator and your physician; and

- Return to work at the time that is agreed to by you, your Claims Administrator, your physician, and your supervisor.

Authorization and Documentation You Will Need to Supply

Upon request from the Claims Administrator, you may need to provide certain information. Failure to provide this information may deny, suspend or terminate your STD Plan benefits. The information includes, but is not limited to the following:

- Signed authorization form for the Claims Administrator to obtain all reasonably necessary medical, financial, or other non-medical information that supports your Disability claim.

- Proof that you have applied for other sources of disability income (i.e., Workers' Compensation, State Disability Benefits, or Social Security Disability Benefits, when applicable).

- Notification of when you receive or are awarded a benefit from another source of disability income, including the:

- Type of income benefit;
- Amount you are receiving;
- Period for which the benefit applies; and
- Duration for which the benefit is being paid (if you are receiving installment payments).

Also, the Company may require a “doctor’s release” to return to work.

Short-Term Disability Plan Benefit Exclusions

The STD Plan does not pay benefits under certain circumstances. These circumstances include, but may not be limited to, the following:

- Failure to participate in or provide the Disability Management Program with all the required documentation regarding your Disability.
- Illness or injury that occurs while:
  - You are on a leave of absence;
  - You are furloughed from work;
  - You are suspended from work; or
  - You are considered an inactive employee.
- Disability that is caused by an intentionally self-inflicted injury.
- Disability that is not being treated by a Physician.
- Disability caused or contributed to by war or an act of war (declared or not).
- Disability caused by your commission of or attempt to commit a crime for which you have been convicted, or to which a contributing cause was your involvement in an illegal occupation.

Other Information

If Your Disability Reaches Five Months in Duration

You should apply for Social Security disability benefits by the end of the fourth month from the day your disability began . (The Claims Administrator can help you with the filing process). In addition, if you are eligible to receive disability benefits from another source, you should apply as soon as possible.

Temporary Modified Work Assignment

If you qualify for a Partial Disability and you are working on a temporary modified work assignment, you will receive your Base Salary for the hours you work and STD Plan benefits (based on the Plan's provisions) for the hours you are not working.

If, in the Claims Administrator's opinion, you could perform a temporary modified work assignment (given your condition) and you refuse the assignment, the STD Plan benefit for which you would be otherwise eligible ends.

Family and Medical Leave Act(FMLA)

While on STD, you may also be eligible for leave under the Family and Medical Leave Act of 1993 (FMLA). If you are eligible for and approved for a FMLA leave for your own serious health condition, your FMLA leave will run concurrently with STD coverage for up to 12 weeks. Please refer to your employer's FMLA Policy for further details.

Continuation of Other Coverages

Certain coverages provided to you under the NiSource benefits program continue while you are Disabled and receiving STD Plan benefits or if you have an appeal pending in accordance with the provisions of the Plan. Any contributions that you are required to make toward the cost of these coverages (including your contributions to a retirement plan sponsored by a Participating Employer) will be deducted from your STD Plan benefits. If your STD Plan benefits are insufficient to cover all of your benefit deductions, MySource for Human Resources will work with you to set up a direct billing arrangement.

Medical, Prescription Drug, Vision and Dental

Medical, vision and dental coverages for you and your eligible dependents continue.

Life and AD&D

Life and AD&D coverage for you and your eligible dependents continues.

LTD Disability

LTD coverage continues.

(*Please Note: If your Disability continues and you meet the eligibility requirements, you may qualify for Long-Term Disability benefits. See the "Long-Term Disability Plan SPD" section of this handbook for details.*)

Flexible Spending Accounts

Health Care Flexible Spending Account

You can continue to make pre-tax contributions to the Health Care Flexible Spending Account.

Dependent Care Flexible Spending Account

Your pre-tax contributions stop. You may use the existing balance in your account to pay for any eligible expense you incur before your Disability begins.

Retirement Plans

You continue to earn service under any retirement plan sponsored by a Participating Employer for which you are otherwise eligible while on STD. In addition, you can continue to make elective deferrals (and the Company will continue to make matching contributions, as applicable) to any retirement plan allowing elective deferrals for which you are otherwise eligible while you are collecting STD Plan benefits. You may, however, stop your contribution to such retirement plan(s) at any time. Please see the applicable retirement plan(s) for further information.

Other Programs

If benefits under the Adoption Assistance Program would otherwise be available to you, these benefits will not be available to you while you are collecting STD Plan benefits.

Claim Denial and Appeal Process

Claim Denial Process

Consideration of the Initial Claim

You will receive a written notice of the Claims Administrator's determination within 45 days of the day the Claims Administrator receives your claim. If due to special circumstances beyond the Claims Administrator's control, the Claims Administrator cannot provide a decision within the 45-day period, the Claims Administrator can extend the review period for up to an additional 30 days. The Claims Administrator must provide you with a written notice of the extension before the end of the initial 45-day period, and the notice will include:

- The special circumstances requiring the extension of time;

If You Have Questions

If you have a question or concern regarding a benefit determination, you may contact the Claims Administrator through the MySource for Human Resources toll-free number (1-888-640-3320) before you request a formal appeal.

If you are not satisfied with a benefit determination, you can appeal it. See "The Claims Review Process" section for additional information.

- The expected decision date;
- The standards for determining your entitlement to a Disability benefit;
- The unresolved issues that prevent a decision on your claim; and
- A description of any additional information that you need to submit.

The Claims Administrator may extend the review period for up to an additional 30 days if it determines that a *second extension* is necessary due to matters beyond its control. If a second 30-day extension is needed, the Claims Administrator will notify you before the end of the initial 30-day extension period of the need for another extension. The Claims Administrator will again provide you with the information noted above.

If the Claims Administrator Denies Your Claim

If the Claims Administrator denies your claim, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- A description of the Plan's review procedures (described below) and the time limits applicable to such procedures.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

Appeal Process

Appeal of Initial Claim

If your Disability claim is denied in whole or in part, you have the right to appeal the decision by sending a written request for review to the Claims Administrator within 180 days of your receipt of the claim denial notification.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided free of charge and reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written request should state why you think your claim should not have been denied. Your letter must include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your appeal, the Claims Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by an individual who is neither the person who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such person.

The Claims Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review, unless the Claims Administrator determines that special circumstances require an extension of time for processing the claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render the determination on review.

If the Claims Administrator denies your appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- A statement indicating your right to file a lawsuit upon completion of the appeal process.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

Appeal to the Plan Administrator

If the Claims Administrator denies all or any portion of your appeal, you or your duly authorized representative may request a review of such denial by the Plan Administrator, by sending a written request for review to the Plan Administrator within 180 days of your receipt of the Claims Administrator's claim denial notification.

You may submit written comments, documents, records, and other information relating to your claim for benefits. Upon your request, you will be provided free of charge and reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

Your written appeal should state why you think your claim should not have been denied. Your letter must include any denial letter you received and any additional documents, information or comments you think may have a bearing on your claim.

Upon receipt of your claim, the Plan Administrator will conduct a review that takes into account all comments, documents, records, and other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in your appeal to the Claims Administrator. The review will not afford deference to the Claims Administrator's decision and will be conducted by an individual who is neither the person who made the adverse benefit determination that is the subject of your appeal, nor the subordinate of such person.

The Plan Administrator will notify you of its determination on review within a reasonable period of time, but generally not later than 45 days after receipt of your request for review by the Plan, unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Plan Administrator determines that an extension of time for processing is required,

written notice of the extension will be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administer expects to render the determination on review.

If the Plan Administrator denies your claim on appeal, it will notify you of the following, in a manner calculated to be understood by you:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- A statement indicating your right to file a lawsuit upon completion of the claims procedure process.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be provided to you free of charge, or you will be informed that such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request.

Physical Examinations

The Company has the right, at its own expense, to have any person for whom a claim is pending examined as often as is reasonably necessary.

Contact Information

If you need answers to specific coverage related questions, contact MySource for Human Resources by going to their Web site or using their automated telephone system. Both the Web site and the automated telephone system can connect you with the Claims Administrator (if necessary).

For…	Contact…
Short-Term Disability Plan	ESIS www.mysourceforhr.com (link to **ESIS.com** 1-888-640-3320 (MySource for Human Resources) You can connect with the Claims Administrator by phone via the MySource for Human Resources automated telephone system Monday through Friday (8:30 a.m. to 4:30 p.m. EST).

General Plan Information

The STD Plan is governed by ERISA (the Employee Retirement Income Security Act of 1974).

Plan Type:	Short-Term Disability
Plan Number:	504
Claims Administrator:	ESIS Two Riverway Suite 1100 Houston, TX 77056
Plan Administrator:	NiSource Inc. and Affiliates Welfare Plan Administrative and Investment Committee
Plan Funding:	Employer's general assets
Contribution Source:	Employer

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